Working with Bereaved People: A Psychotherapy Training Action Research Study: Working Towards an Epistemology of Grief as the Therapeutic Approach with a Bereaved Population.

Submitted in part fulfilment of the requirements for the Doctorate in Psychotherapy by Professional Studies

A joint programme between the National Centre for Work Based Learning Partnerships Middlesex University and the Metanoia Institute

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Abstract

The absence within professional trainings of the phenomenological experience of bereavement, loss and grief has created a gap in the knowledge of professionals working with bereaved people. Adherence to and rigid use of traditional models neither meets the emotional nor psychological needs of those bereaved, whilst the experience of traumatic death and loss has been largely marginalised or discounted in bereavement counselling and grief therapy. Lack of emphasis upon the individual, phenomenological experiences of bereaved people and an over emphasis on schoolism in psychotherapeutic trainings have further contributed to a frequent failure in therapeutically meeting the lived experience of those who encounter both prolonged and traumatic grief experience.

This research challenges psychotherapy practitioners to adopt an epistemology of bereavement founded upon loss and grief phenomena in lieu of a specific theoretical orientation and approach to practice. It further aims to ameliorate therapeutic benefit to the client group by developing practitioner insight through an inter-professional lens. Thus, by extending the knowledge base of practitioners, the hoped- for aim is to better inform the practice of professionals who are engaged in working with bereaved people.

An action research approach was adopted in trainings with adult professionals using a co-operative action research methodology underpinned by action research science. A teaching and learning paradigm underscored the interlocking action research cycles formulated on Heron and Reason's (2008) extended epistemology of fourfold 'knowing'. Participants' responses and contributions were captured to identify their engagement with the training content and its applicability to their work with clients. Participants were drawn from eight different psychotherapeutic trainings and extended cycles separately involved homogenous student focus groups from Child Nursing and Counselling & Psychotherapy.

General findings from the research identified the significance of key professional stakeholders to the psychological well-being of bereaved people and the importance of inter-professional collaboration and exchange of profession specific knowledge for the benefit of both the bereaved and those working with them in a professional context.

Specific outcomes were: Client Narrative, Interpersonal Assessment Form for Bereavement; a set of 5 diagrams for transtheoretical psychotherapy training; a Teaching, Learning & Quality Matrix as an ipsative formative assessment tool.

Keywords: Bereavement, traumatic grief; transtheoretical paradigm, inter-professional learning, mimetic traumatisation.

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Chapter 1: Introduction

5.8 The starting point

In 2003, I believed my engagement with this research began with and arose from my role as Director of Wandsworth Bereavement Service (WBS). Whilst certainly the research activity emanated from the opportunities created by this position, the D Psych journey has exposed deeper, much earlier roots to my personal encounter with loss and grief. Fascinatingly, though not surprisingly, as I became more immersed in the research process, so the awareness of my own psychological contact with one of life's most frequent, naturally occurring phenomena, has greatly increased. In effect, the ontological and epistemological foundations to this research project only came into my conscious awareness as I symbolized (Rogers, 1951) significant events in my life. These emerged whilst on this doctoral journey yet have been present throughout my life leading me to embrace the field of bereavement in a long term, professional context.

At a cognitive level, my initial intention was to consolidate learning derived from substantial and very wide practice based evidence (Bower, 2010) and latterly, to consolidate all learning from my participation in this research programme including the earlier D Psych submissions, namely the RPL, RAL 4 and LA. Subsequent insights from these, have contributed to understanding and locating myself in the research as a practitioner-researcher (McLeod, 1999; Sanders & Wilkins, 2010), giving me an awareness of my ontological development

(Lawlor, 2002) and epistemological roots (Pietersma, 2000). In turn, this engendered an engagement with action research for the purpose of enhancing practice (Kemmis, 2009) when working with a bereaved client group.

As I immersed myself in the material, more in-depth revelations occurred and I have been able to identify and symbolize significant moments and events in my personal life which are elements of my own phenomenological experience and tacit knowing (Husserl, 1931), yet are integrated into my whole being as a person and a psychotherapist. I have come to understand how loss and grief are such integral parts of both my personal and professional life journeys that they have merged together. Here, I am reminded of the Jungian concept (Jung, 1921) of 'Individuation' which he saw as a natural process, either with or without the person's knowledge. He regarded this to be a result of what he referred to as a co-operation between collective[1] and individual aspects of a person's development. On this issue, Papadopoulos (1998) states 'the collective and personal aspects of our identity interweave to create the unique tapestry of our specific individuality' (p. 61). He goes on to say, '[ ] the process of development in every individual is the appropriate negotiation [ ] a working balance and 'co-operation' between the collective and personal dimensions' (ibid). Recognition of this during the current

[1] Jung's term collective refers to: a) the inner collective unconscious exerting a formative presence on ego development and b) the outer conscious influence of the wider collective in terms of social and cultural influences.

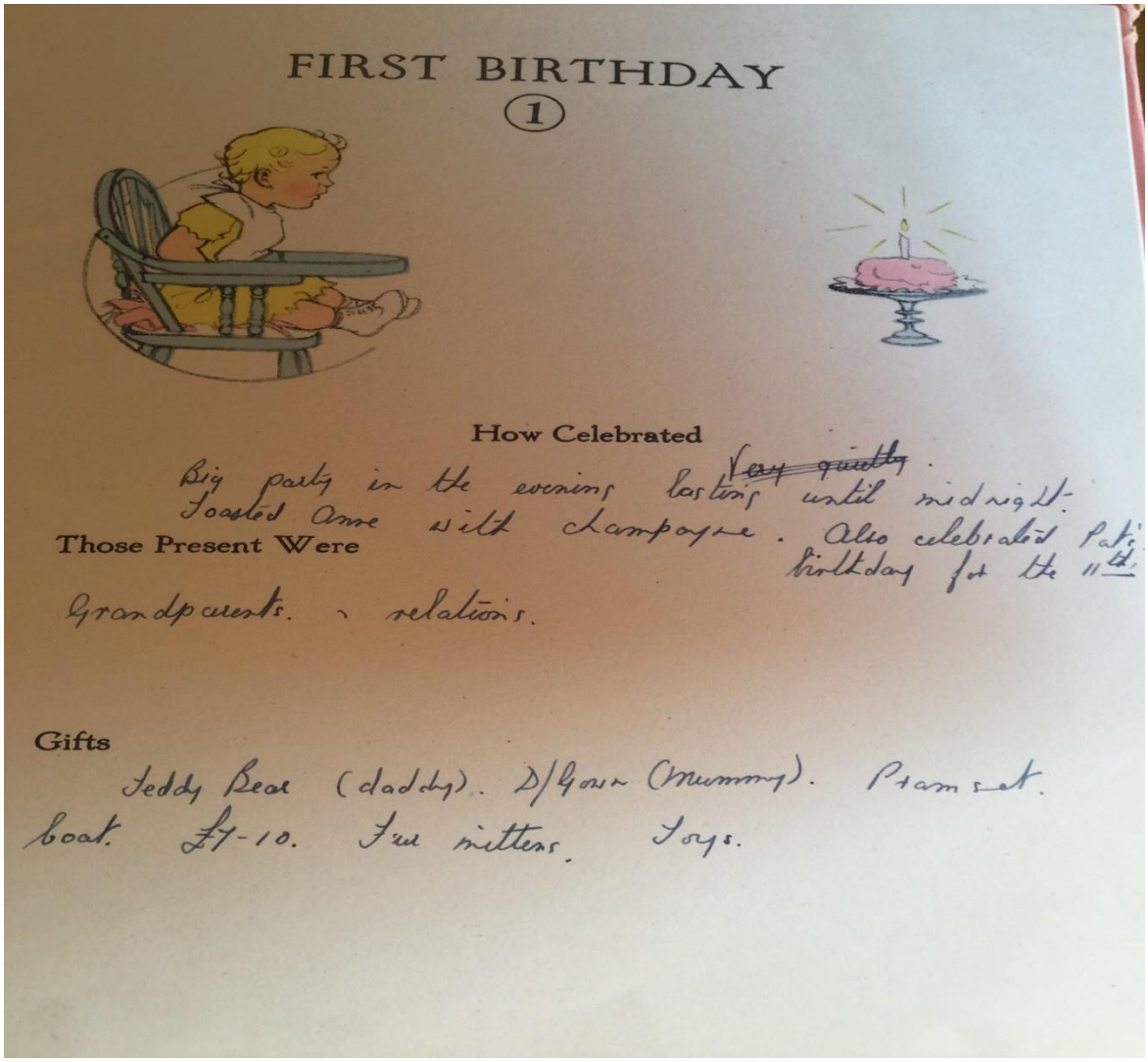
study has been important, enabling me to acknowledge the negative element and impact of my own familiarity with loss and death within my professional role and work, specifically that of a trainer. This integrated knowing and unknowing, with both positive and negative connotations, has impacted from (my) early beginnings upon my personal and professional development and of which I only became aware after 20 years of practice.

1.2 Early beginnings

Epistemologically and as practitioner, I sit firmly within the person-centred, contemporary tradition of psychotherapy. Interestingly, through this research journey, I have encountered the power of the unconscious and although earlier in my LA submission, I highlighted my first conscious, experiential encounter with loss and grief when my grandmother died, it was not until 2008 that I recognized an even deeper, more intimate revelation: the absence of affectional bonds (Bowlby, 1979, 2005 R.P.L. Bowlby et al.) with my mother.

I had always tacitly and intuitively known (Moustakas, 1994) its absence in my childhood and early adult years and had 'felt it in my bones' as grandma would have said. However, I had never been able to articulate it nor indeed understand it, especially as my mother remarried when I was 8 years old and a good, happy family home and lifestyle was established. My reflexive diary entry reads: 'So, so sad, and shocking seeing this. And very comforting for me; so here it is…' (24/1/2008)

On visiting my mum for her 90th birthday, she offered me my Baby Book from 1950 which I did not know existed. In reading it through, I was struck by the shocking realisation of how my mother's grief over my father's death when I was 18 months old, had impacted upon her and thus upon our own mother/ child relationship. My mother had diligently filled in the different sections, mapping my development and first birthday celebration and gifts. The second birthday entry was not celebratory and thereafter, all entries came to an abrupt stop with the remaining pages of my baby book remaining totally blank:


FIRST BIRTHDAY

1

How Celebrated

Big party in the evening lasting until midnight. Toasted Anne with Champagne. Also celebrated Pat's birthday for the 11th.

Those Present Were

Grandparents & relations.

Gifts

Teddy Bear (daddy). D/Gown (Mummy). Pram set. Coat £7-10. Fur mittens. Toys.

Figure 1

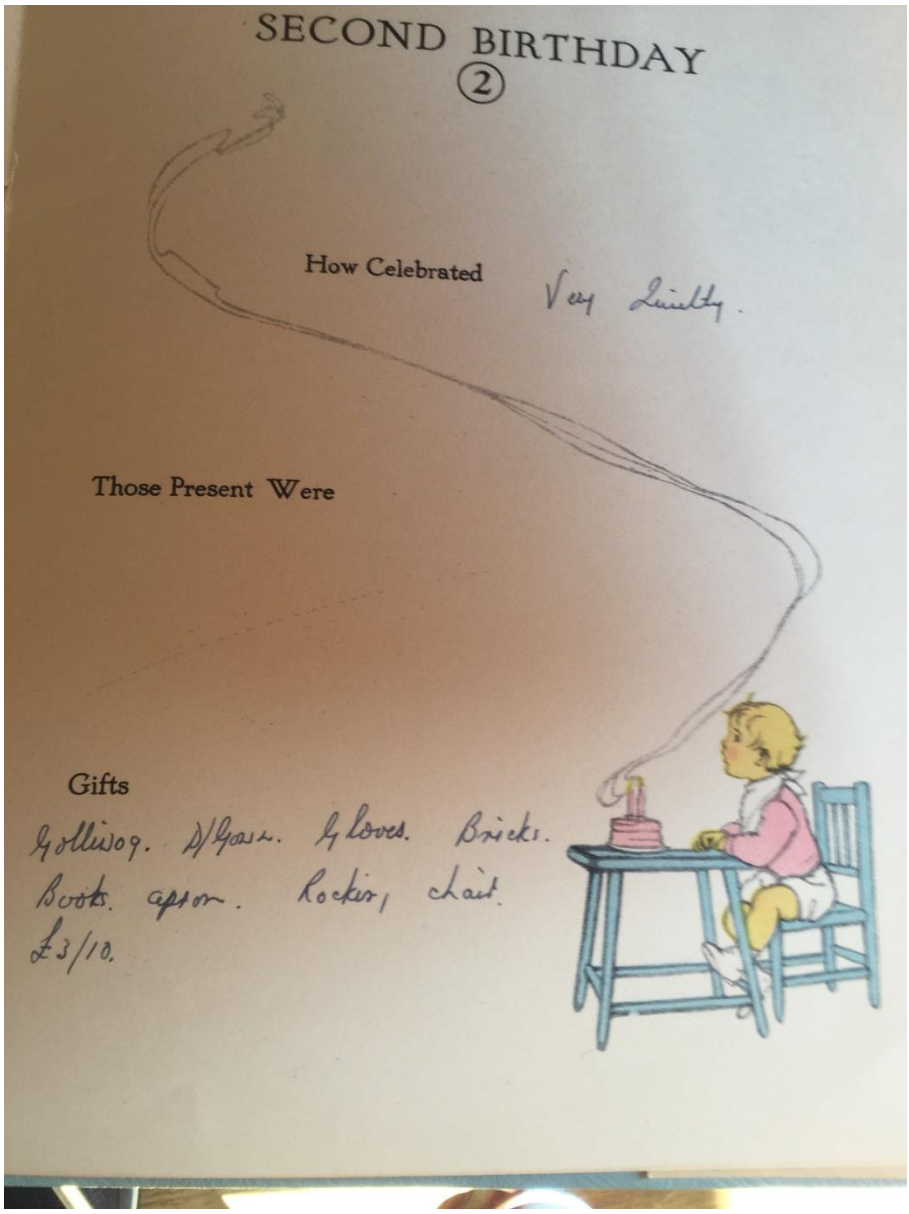


Figure 2

Staring at the blankness, in that moment, I experienced shock, sadness and thankful clarity with explicit knowing. It made sense. I now comprehended there had been an emotional rupture in our relationship which had neither been healed nor overcome. I understood why my first memory of my mother was when I was 7 years old; why grandma and granddad were such significant others in my

childhood. In truth, I had always ‘known’ they were my ‘secure base’(Bowlby, 1988); that I had never felt emotionally attached to nor a special bond with my mother; that I had never had any experience of her pride and joy in me, nor expected her to have and why I never ‘knew’ she loved me. This was a bitter-sweet experience: a shocking reality about the huge sadness for my mother coupled with an understanding that I was not the cause of her lack of bonding with me, experiencing simultaneously a greater increase in my compassion and respect for her.

Just as I thought I had finally grasped the heart of it, my husband in October 2009, informed me of yet a further revelation. My mother had told him of her ambivalence on hearing she was pregnant with me. For 12 years my parents had tried to have a baby after which period, having accepted that was not going to happen, they immigrated to South Africa via my father’s job. On learning of her pregnancy, my mother was not happy; she was ambivalent about my existence. She had anxiety about being a mother; afraid she would not know what to do, how to look after a baby; my arrival would dramatically impact upon their happy life in Durban. She decided to return to the UK, to live with her parents where she gave birth to me in their home. My father returned to the UK when I was 12 months old where he too lived until his death 6 months later. And I was 5 years old before I knew I had a father; a fact I learnt when being punished at infant school by the catholic priest who said: ‘Your father will be turning in his grave’.

Despite, however, such invested personal interest, my research does not follow that of the heuristic tradition (Moustakas, 1990) to discover through total immersion in an *heuriskein* enquiry, nor indeed an auto ethnographic approach (Speedy, 2008) steeped in my own phenomenological, social and cultural experience. Rather, it is specifically designed (Creswell, 2009) to bring about changes in training content and delivery methods through co-operative participant inquiry to ' find out how to do things better' (Heron and Reason, 2001: 179).

1.3 Integration of the personal and the professional

Although I do not dedicate further space to my own historical, chronological narrative (and additional losses), I believe it is important in the role of researcher to comment on how my own unconscious processes (Jung, 1921) offer an explanation as to why I am so familiar with and comfortable around loss without becoming overwhelmed by it. More particularly, when encountering huge and multiple losses in others, I know I can accommodate my clients' processes without being overwhelmed. Such relatively recent conscious awareness has contributed to my semantic and explicit knowing and has provided an explanation to others' questioning and curiosity about my capacity to do so much bereavement work and for so long. It further explains why I have been so intrinsically drawn towards professional engagement with loss and death in

diverse ways which in turn has, I feel, enhanced and significantly informed my professional contribution to psychotherapy training.

For instance, at the announcement of Michael Jackson's death, I took a bus to Shaftesbury Avenue, speculating that tributes would be placed at the Lyric Theatre where 'Thriller' was (and still is) showing.

Visual Data & Research Field Notes of 27th June 2009

Tributes placed in the doorway of the Lyric Theatre, location of the 'Thriller' musical production, by 10.20am on 27th June following the announcement of Michael Jackson's death, night of the 26th June 2009.

Bouquets of flowers; lit, long burning candles; cuddly toys and written tributes.

Figure 3

A Doorway Shrine to Michael Jackson

(27/6/2009)

Notable on this day across London, the loud playing of MJ's albums emanating from Hair Salons, balconies of private apartments… not just as a tribute but as if, in his death, it was again acceptable to publicly acknowledge enjoyment of his musical talent which has been so 'denied' or seemed shameful to admit to since his trial for CSA.

'Lovely, looking up, walking past apartments blasting out 'Bad' and 'The way you make me feel' (1987) – good to hear these favourite tracks again. Wonder now, does his death symbolically mean it's OK to forget the past, or to forgive and forget so we can now renew love of his music and let it back into our lives, free from moral dilemma.' *Reflexive journal entry 27/6/2009.*

Figure 4

A Paper Headstone by Gray '09

A beautifully drawn and striking design characteristic of a headstone carved with the deceased's years of birth and death, and an epitaph. Here the author of this tribute has used the title of one of Jackson's own recordings 'Gone Too Soon' (1991). The pencil drawing captures the well- known straggly Jackson hairstyle with its notable wavy strand falling down the centre of his face.

'Such a likeness; even without the writing, you know it's Michael Jackson. Something so beautiful and simple about this tribute. Feels like the author truly appreciates MJ, the artist and has created his own artistic homage. I'm struck by how permanent this artefact feels despite it being of paper and having been done in less than 24 hours and being stuck onto a wrinkly black plastic bag; it looks perfect! And the signature in red is intriguing: is it an exact copy of Jackson's signature or poetic license and what does it mean? People's signatures don't usually appear on things after their death.' *Reflexive journal entry 27/6/2009*

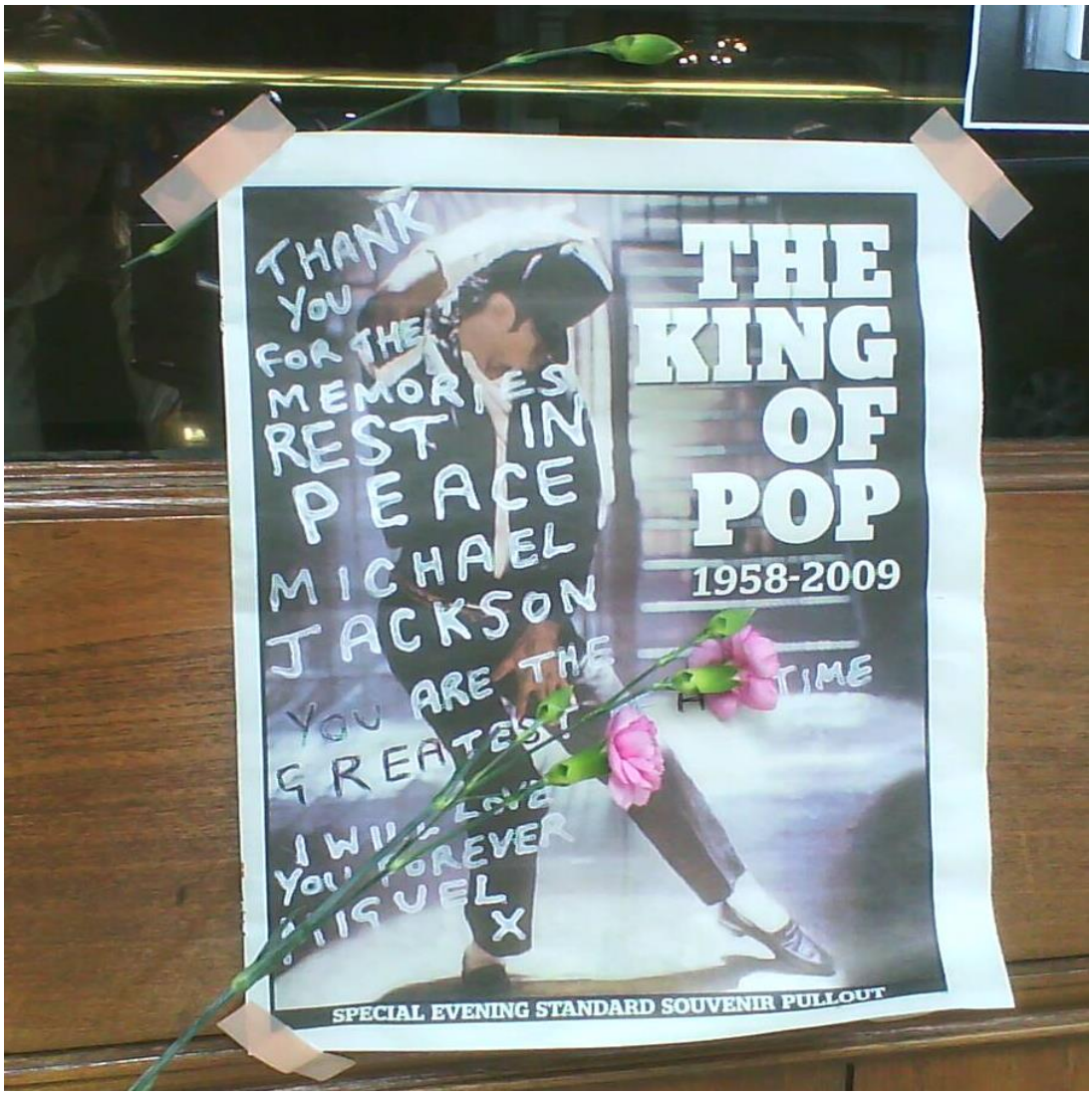


Figure 5

A Heartfelt Message to Michael Jackson from Miguel

A personal message written across the Evening Standard's special edition. The 'author' taped the newspaper front cover across both the glass window and wooden door parts of the theatre entrance and then a pink carnation stem across Michael's photo in 2 parts.

‘This tribute has a feel of resourceful haste to fulfil a need to honour MJ with whatever resources were available to him; the important thing being to go to the Lyric Theatre and to deliver his message. Poignantly, ‘rest in peace’ is written in larger capitals than either his ‘thank you for the memories’, ‘the greatest’ or ‘I will love you forever’. As I notice this, I feel both deep sadness and a kind of truthful resignation equally about MJ – feels easier now that he no longer lives. Is it us that can now be at peace- released from ambivalent feelings? Is it ‘cos he could no longer harm anyone, so others are safe and therefore it is safe and OK for me to feel sadness? Is it ‘cos it is easier to believe he was guilty after all now that he is no longer here?’ *Reflexive journal entry 27/6/2009*

Such tributes carry a recognition of idolization and are often perceived as being only that with the deeper intrapsychic meaning of loss to the individual being dismissed and discounted. As a practitioner, I value the individual’s idiosyncratic nature of their grief and believe this needs to be met in the therapeutic space whilst equally recognizing the complexity that abounds multiple concepts of idolization, idealization and idiosyncrasy.

In this regard, the death of Princess Diana significantly highlighted such complexities creating a platform for both those who mourned and for several critics of the mass outpouring of grief. At the time of Jackson’s death in 2009, the words of Papadopoulos on Princess Diana’s death in 1997, resonated strongly as global phenomena:

> ‘The genuine expression of grief, glorification and spirituality, in addition to the host of other factors (from political to voyeuristic), made that single event acquire mythical dimensions. [] from a star to an icon, allowing people to elevate her to a more permanent state of sanctity []. Now unperturbed by the vicissitudes and oscillations

> of her personal life, as an icon, Princess Diana was offered for full veneration. Icons, as we have seen, restore the 'fallen image to its former state by uniting it to divine beauty' (Ouspensky, 1978: 180)[2]. Similarly, the 'virtual icon' of Princess Diana created a comparable virtual effect: forgiving the folly of her personal life, people gave an astonishingly uninhibited expression to their need to glorify her icon.' (Papadopoulos, 1998: 72).

On Friday, 6th September 1997, I had joined the hundreds of people sleeping overnight on the pavement in Pall Mall, prior to Princess Diana's funeral cortège passing on its way to Westminster Abbey. Having learnt through all the media coverage the extent of the nation's grief and as Director of WBS, I had felt professionally drawn to observe this very public demonstration of mourning on such a mass scale. I personally had neither placed flowers nor queued to sign the remembrance book, nor ever felt a desire to do so, yet I did feel personally propelled to be there; I just had to go and be present to share in this experience.

During that evening, I was struck by the overtly respectful and shared experience as people made way for each other as they walked, bent down to read messages placed with flowers, cuddly toys or candles, or patiently waited to arrange their own tribute. Incongruent in another context perhaps: diverse ethnicities, punks,

[2] Papadopoulos cites Ouspensky, L. (1978) *Theology of the Icon.* Redondo Beach, CA: Oakwood Pub.

bikers, heavily facially pierced individuals, Muslim couples in their traditional dress, the Hindu women in their saris and red tikka on their forehead, the gay couple with arms around each other and heads bowed into each other‘s, the hard gay ‘clones’ and the ‘Hells Angels’ holding a single red rose; people of different faiths, diverse cultures, ethnicities, ages, sexualities and social status, all walked sorrowfully and respectfully amongst each other. Many men, women and teenagers were crying without feeling the need to hide their emotional response. Not all would be sleeping out but even at 1am, such was the scene on The Mall.

In 1998, a group of Jungian analysts wrote ‘When a Princess Dies’ in which Papadopoulos further wrote:

> ‘She (Diana) was as ‘universal’ as one can get today, with exposure across most boundaries: geographical, cultural, linguistic, religious, ideological, racial, socio-economic, gender and age’ (Papadopoulos, 1998: 70).

Andrew Samuels wrote of socio-political change and coined the phrase ‘political aspirational atmosphere’(Samuels, 1998: 40). It is the word ‘aspirational’ which I regard significant for I believe Diana represented so much hope to so many people and her death was experienced as a loss of hope to humankind. Haynes and Shearer wrote:

> ‘When she died, the nation seemed to discover that Diana’s contradictions were their own: she connected with the hidden depths of our most shallow desires and the heights of our deepest longings.’ (Haynes, 1998: 6)

It is, however, another Jungian contributor, Fitzgerald, who has provided a more poignant response to the intrigue around such unprecedented global mourning, as follows:

> ‘I came across a book published after Diana’s death, called *Dreaming of Diana* (Francis, 1998). In this, men, and women from all walks of life tell of their dreams of Diana. The moving thing for me was the sense of the intimate place this woman had in the psyches of so many people. Whether as man’s anima or woman’s shadow or greater self, the wonder is that this one frail, fallible human being who was stumbling her way towards a collective role she seemed to sense dimly within her, was the single carrier of so many unconscious projections, and had a unique place in the psyches of so many people.’ (Fitzgerald, 1998:92)

On the eve and the morning of Diana’s funeral, Fitzgerald’s words, albeit a year later, had been palpably evident through the intense levels of distress and pain clearly visible on people’s faces and in their bodily responses. It was, however,

the more unique rather than the collective manifestation of mourning that more poignantly captured my attention. Figures 6 and 7 below both symbolize an idiosyncratic tribute and expression of mourning.

Figure 6
Green Park the evening before Princess Diana's funeral.
Friday, 6th September 1997.

I wondered what this very private tribute meant, being placed in isolation in Green Park, far away from the crowds and the Mall. Of course, I had no real answer and so speculated on possibilities: aloneness or not wanting to be seen;

anxious in crowds; needing to individualize the tribute in commemoration of Diana rather than being just one of the many; not needing to be part of a public mourning in order to experience the loss and mark the importance of Diana's life and existence to self? What was the intrapsychic meaning for this 'author'?

Figure 7
Crowds dispersing from Pall Mall after the funeral
Saturday, 7th September 1997

Figure 7 offers a photographic image of one person's unique, idiosyncratic tribute to Diana. I remember vividly how other public mourners kept a wide berth, were taken aback and looked in surprise at this particular display of grief. I was intrigued and wondered what Diana represented or symbolized for him – who was she for him? What was the deeper intrapsychic meaning for him of Diana's life and now death? I could only be left to wonder what place Diana had in this person's psyche and knew that the answer could only come from that person alone.

The Princess Diana and Michael Jackson phenomena represented on a global scale the specific grief concepts of idealization and intrapsychic meaning. Idealization is a defense mechanism (Freud, 1917) which mitigates against less positive aspects of a person or situation whilst intrapsychic meaning represents the 'pure essence or eidos' (Husserl, 1931) of relational experience. These are fundamental to and crucial in psychotherapeutic work with bereaved people though are not, of course, confined to those with iconic celebrity status. They can be present in many instances of grief and also respectively be used politically and experienced socially on a wider scale as demonstrated in our recent UK history in respect of young soldiers killed in action.

1.4 Personal, political and professional perspectives

Wootton Bassett became Royal Wootton Bassett on 12th March 2011 by decree of Elizabeth 11 'as an enduring symbol of the nation's admiration and gratitude'

(Cameron, March 2011). The year 2011 marked the end of RAF Lyneham as the base for the repatriation of men and women of the British Armed Forces killed in Afghanistan and Iraq, with this function returning to RAF Brize Norton. The drive from RAF Lyneham to the Oxford hospital where family members were waiting for their deceased loved one, needed to pass through Wootton Bassett High Street. Over the four year period (2007-2011), however, through the media we witnessed an ever increasing ritualistic pattern develop: Initially local passers- by on the street showed respect in standing still (a custom of old), then the British Legion became involved to line the street, subsequently joined by hundreds of local residents, shops closing, the Mayor and other local dignitaries also in attendance and a slow, funeral cortège complete with funeral director walking in front of the hearse. Latterly, thousands were reported to have attended, including a large flotilla of hundreds of bikers.

Here, I own my prejudice and personal view as someone who never appreciated the socially constructed (Neimeyer, 2009) Wootton Bassett phenomenon, experiencing it instead as a glorified mask which belied the truth and real tragedy. I felt and believed this glorified and idealized ritual did not represent the full reality for bereaved relatives: the repatriated bodies had to be again repatriated across different counties to the deceased's home town to undergo a Coroner's inquest into their death. The fact that they were killed in action did not exempt them from a sudden death inquest.

Controversy over Diana's repatriation arose over this very issue whereby, despite it being UK law, no such inquest took place much to the disbelief and disagreement from the Coroner's Office (Research participant CO, 2010). As a consequence, no Coroner's investigation into her death took place whereas, those for dead soldiers did at times reveal causes of death due to inadequate battle clothing, poor equipment and even vehicles not fit for purpose for fighting in war zones. Failings being recorded by Coroners as the true and real cause of death lead to 2,003 civil claims of death plus damages against the Ministry of Defense (MOD) by bereaved relatives and injured soldiers (BBC News Northwest, 19/10/2012, 6.30pm).

The publicly conducted funereal like processions gave a false impression to the nation which I found personally abhorrent for its idealized view and veneration of Wootton Bassett, attention to which ranked higher than the tragic loss of so many lives, several through inappropriate resourcing. This was compounded more so by the equally idealizing verbal tributes paid by commanding officers to the 'fallen' – a preferred term it would seem by its frequent usage rather than acknowledging someone's life had been brought to a violent end. The publicly articulated phrase of 'the best soldier' became commonplace with every repatriated body and, cynically, I asked myself how many can realistically be 'the best' and several at the young age of 19 or 20?! These constant accolades, I felt to be disingenuous, used as political PR. Notably, since repatriation returned to

Brize Norton, neither the ritual nor Commanders' tributes appear in the media and again, cynically perhaps, I ask myself whether the idealizing tributes were intentionally introduced to create a more positive public opinion given the media coverage at Wootton Bassett of dead soldiers returning home. And a jaundiced view, no doubt, is that of the title of Royal having been bestowed as a political strategy to elevate Wootton Bassett by making it the third only town in the UK to receive this regal title, the second occurring in 1909. In doing so, this would mitigate against any potential ill feelings or disappointment from its residents who had invested so much into the 20eco of being the nation's receptacle of grief. Or could it be a covert strategy to hide and mask the truth that politicians and the military had become uncomfortable with such coverage?

My own personal and political stance, however, is potently challenged by the bereaved relatives' experiences and the intrapsychic meaning to them of the repatriation processions, as well as significant meaning to the local population of Wootton Bassett. My personal view has no place in this and is irrelevant as to what is meaningful to them. With reference to the repatriation of Lt Douglas Dalzell, on 25th February 2010, the BBC News reported:

> 'Family and friends lined the streets of nearby Wootton Bassett, where the men's cortege passed through.
>
> [] one of Lt Dalzell's closest friends had come from London to pay tribute. Asked why he had made the

> journey, Mr Molavi said: "Because he was my best mate. I think it is a great turn out and the people here are very accommodating. That makes it a lot more bearable.'

This represents only one example of hundreds of people who found significant meaning and solace in the collective, socially constructed ritual to honour those who died in warfare. Essential then, to transcend personal politics to learn about the experience of others and citing Husserl who stated that fact and essence are inseparable: 'Natural knowledge begins with experience (Erfahrung) and remains *within* experience' (1931: 51), to equally honour all bereaved experience.

Practitioners working with a bereaved client group need to be available to the client's experiences. Voices, therefore, of bereaved individuals must be heard and responded to therapeutically and considered significant whether a single or collective voice. I concur with Lebow (2006) who emphasizes the relevance of practice to research and questions the over dominance of evidence-based practice, promoting instead a mutually informed learning between psychotherapy and psychotherapy research. In this regard, I position myself as a practitioner-researcher who places the emphasis for conducting research upon practice- based evidence (PBE) as opposed to evidence- based practice (EBP).

1.5 Study foundations: practice- based evidence

This research study is underpinned by practice. Voices of those with whom I have engaged therapeutically as clients are represented in the Appendices. These are but a few examples from cancer patients and bereaved relatives at Whiston Hospital in the period 1991 to 1996 and WBS client voices.

Learning from the client population at WBS was fundamental to my clinical management of the Service and its future developments in the period 1996 to 2005. In 1996, on arriving at WBS, I immediately replaced the brief detail and basic telephone 'assessment' form with a one- hour face to face assessment for all clients. The assessment form was then reviewed and updated every 2 years in consultation with a team of assessors, qualified and experienced therapists, and supervisors to account for greater insights and understandings gained from the client population: client narratives describing their individual, holistic experience of being bereaved. Appendix 2 is the latest version, designed as an interpersonal assessment tool between client and therapist. It is divided into sections to reflect different aspects of the bereaved person's emotional, psychological, contextual and experiential situation to represent the whole of their phenomenological experience.

The WBS annual statistical data bases are presented in Appendix 3 to evidence the wide nature of the bereavement work and the demography of the client

population over a ten- year period, 1999-2009. The year 2004 saw a reduction in numbers as this represents the year when Wandsworth Borough Council suddenly withdrew all of its funding and the organization and I went into 'survival mode' (Carroll, 2005) and fought the Council at local level and in Parliament (Hansard, 2004) as evidenced in my RPL.

Although not collected and collated expressly for research purposes at the time, the data was collected for empirical evidence of the bereavement work being conducted which eventually led to WBS being fully funded by Wandsworth NHS primary care service from 2005 and remains so to date in 2017.

Together, these three appendices form the practice- based evidence upon which my training materials are founded, the latter of which are the essence of this action research project.

1.6 Concluding thoughts to this introductory chapter

As an enquiry firmly rooted within the qualitative paradigm, locating the researcher in the research topic has been essential (Silverman, 2010). As previously noted, the ontological and epistemological foundations to this research project only fully emerged whilst on this doctoral journey, raising psychotherapeutic awareness of 'self' and the philosophical beliefs and values I hold. Such self- knowledge emerged when drawing upon my own reflexivity

within the established tradition of the qualitative researcher making transparent use of the reflexive process (Etherington, 2004; 2005).

During this chapter, some key elements have emerged which bring bearing and pertinence to the research activity and study. These I highlight below:

- Individual, intrapsychic meaning and symbolization
- Idealization and idiosyncratic grief reactions
- Socially constructed phenomena and phenomenological experience
- Researcher bias, agenda and reflexivity
- Practice based evidence and evidence-based practice as empirical evidence

Within these are challenges to me as a practitioner, both theoretically and in practice, and additionally as author researcher for this project. These become transparent in the ensuing chapters.

Chapter 2: The Literature Review

2.1 Introduction

In conducting the review, I have appreciated the work of Ridley (2008) and Hart (2001, 1998). They have influenced the style and structure of this document and, in particular, my approach to and use of literary contributions. Essential to this, is my choice to adopt a recursive approach rather than a dedicated chapter (Ridley, 2008). A single, dedicated chapter where all the relevant literature is located and considered would not coherently facilitate thematic connections throughout the reading of the document. Ridley (2008) sees the recursive style as starting in the Introduction and expanded upon in subsequent chapters with the researcher 'revisiting and adapting' (2008: 29) as themes are developed. She further recommends that the literature review also serve to identify specific meanings of concepts and terminology pertinent to the research topic and writing of the document.

To this end, I start by identifying how I am using the terms bereavement, loss and grief whereby bereavement is used throughout as a generic description intended to signify an event that has taken place involving major personal loss to individuals which subsequently generates the individual's emotional response and process to their unique loss, referred to as grief or grief process. When referring to bereaved people or a bereaved client group or population, therefore, I do so with the understanding that each person within that group will have their

own unique grief process which is informed by the particular nature and circumstances of the loss that has occurred.

My intention throughout this chapter is to highlight my own conceptual and critical thinking by adopting a writer's voice to establish an authorial self which is grounded in my own practice- based evidence and underscored by clinical and theoretical relevance in existing literature.

2.2 Rationale for use of artefact material

A key element to the writing of this study, concerns a substantial use of 'grey' literature in the text. Hart (2001) presents detailed documentation of different types and categories of grey literature sources. This has encouraged my use of televised documentaries, Crown reports, conference keynotes, emails, lyrics, creative writing, newspaper articles, unpublished material and web sites as data and empirical evidence. He describes grey literature as: 'A range of published and unpublished material which is not normally identifiable through conventional methods of bibliographic control (e.g. ISBN's and ISSN's) is called grey literature' (2001: 94). In this category, he further refers to 'other types of ephemera including objects commemorating an event, websites, virtual discussions …' (2001: 94).

Stake (1995) promotes the use of 'artefacts' for data collection and in line with this, I draw upon the use of visual aids and materials such as photos, objects, U-

tube and DVD's as training materials appropriate to naturalistic phenomenological research.

The work of Yin on case study research is well established and in his fourth edition (Yin, 2009), he presents six sources of evidence of which 'Physical artefacts' is one. In his Figure 4.1, he identifies strengths of physical artefacts as 'Insightful into cultural features' and 'Insightful into technical operations' (2009: 102). Weaknesses he describes as 'Selectivity' and 'Availability' (2009: 102). As a trainer-practitioner-researcher, I strongly contend Yin's identified weaknesses, viewing these as crucial, additional strengths in the art of training. Selectivity in the use and choice of artefacts is an essential dimension, augmented further still by extremely careful, sensitive, knowledgeable selection. Indeed, it is the process of careful selection which ensures optimum cultural sensitivity, awareness and insight. Availability of artefacts can present a challenge to a trainer. However, once again, this becomes an added strength to a training programme, creating opportunities for, and even demanding, diverse ways in which to present material that captures ethnographic significance. Yin states: 'evidence is a physical or cultural artefact – a technological device, a tool or instrument, a work of art, or some other physical evidence. Such artefacts may be collected or observed as part of a case study and have been used extensively in anthropological research' (2009: 113).

Use of appropriate artefacts to this study forms part of the collective body of resources which contributes to the quality of the teaching and learning. Visual data is thus an important medium throughout this project, used to convey meaning and supported by Banks (2007) as a powerful source of data collection and interpretation. At this point, I invite the reader to look out for later reference to 'The Owl', 'The Spider' and 'The Animal Odd Couple'.

2.3 Locating myself theoretically in the literature and researcher role

Awareness of the plethora of published literature pertaining to loss, death, grief, bereavement and, though much less so, for complicated grief and traumatic bereavement; these were key terms for my academic searches using Boolean logic. However, this study is not a systematic review (Brettle, 2008) and to attempt a review of most published material on such a vast subject would have reduced it to a piece of 'armchair research' (Ridley, 2008).

Such a concept is antithetic to the ontological and epistemological foundations to my work as a practitioner and this research study. In discussing 'person experience as inclusive' Heron (1998: 12) raises the question of 'ontological incoherence' (1998: 13) and writes:

> 'It is improbable to suppose that any human being, embodied in a physical organism, and embedded in a prevailing culture, as well as in a local subtle ambience, can at the same time be totally absent as a knowing subject …' (Heron,1998: 13).

Ontological coherence, therefore, is achieved through a synthesis of the whole person's experience. Here, I make a connection with knowledge gained through experiential knowing and the concept of 'explicit memory'(Siegel, 1999). Building on this perspective in relation to client work, I argue that the neurobiological concept of 'implicit memory' (Siegel, 1999) will be associated with knowledge gained through unconscious knowing, or knowledge that remains either outside of conscious awareness or at the edge of awareness (Rogers, 1951). This implicit knowing can be accessed, or symbolized, through therapeutic dialogue to reach a coherent narrative which accurately captures the client's experience.

Heron links ontological incoherence with the 'participatory theory of knowing' (1998: 12). Given my own first -person phenomenological experiences and hence necessity within this field for my own 'epoché' (Husserl, 1931), I argue it would not only be incoherent but ontologically incongruent if I did not acknowledge the realities and truths of my own real world experience and research inquiry (Moustakas, 1990). Similarly, inclusion of second person phenomenological experience lies at the core of my study, in order to expressly represent the lived experience of others (Robson, 2002; Speedy, 2005). I assert that prior research projects I have undertaken contribute to my ontological coherence and congruence. Specifically, these are:

- 1988: PG Diploma; An Enquiry into the Experiences of Adult Survivors of Child Sexual Abuse
- 1997: MA research; An Enquiry into the Emergence of Trauma Post Diagnosis and Treatment for Cancer
- 2000: Jamaica; informal, research by enquiry with indigenous people on bereavement to inform WBS work with the Black British Caribbean community in Wandsworth, London
- 2004: Goa; for a Goan Mental Health NGO 'Sangath'; 'Goan Teachers' Experiences of Bereaved Children'.

Heron also refers to 'ontological acquaintance' (1998: 68) as leading to 'authentic, subtle experience' (1998: 68) and Kierkegaard's 'real subject', that of the first person. I am reminded of my philosophical origins and their subsequent influences to my background and development in the field of psychotherapy. Silverman (2010) states it is important to understand the role of the researcher; their personal values, beliefs and how the personal history of the researcher impacts upon the research. Similarly, Schwandt (2003) claims it is essential to identify personal values and beliefs which are the epistemological cornerstones of the researcher.

During this study, I have from time to time been drawn back to reflect upon my own earlier education. My exposure to philosophical literature began with the great French philosophers moving to the more contemporary French existential philosophies of Malraux, Camus, Sartre and St Exupéry. Nietzsche's 'nihilism' and the metaphorical narratives and biographies of ancient Greek philosophers also encompassed my early introduction to the complexities of human existence and human relationships. What clearly spoke to me at a visceral level were the stories in the literature which told of and expressed human frailty and suffering often portrayed alongside the juxtaposition of robustness and resilience; the human capacity to survive and withstand incredible painful life events and experiences.

Stories of emotional pain, harm, hurt and the phenomenological nature of it, have tended to stay with me and often I have felt, like many, deeply touched by the pain and sorrow inherent in them. Stories epitomize existential truths and the stark reality of the cruelty in life. At times symbolically represented in fiction, as in 'La Peste' (Camus, 1946), or accurately produced as semantic fact in 'Dr Harold Shipman: Prescription for Murder' (Whittle and Ritchie, 2005). Again, like many, I have questioned why the phenomenon is so and believing it did not have to be so, it was surely not scripted; it could have been different if only…

Conversely, are the multiple realities and truths which naturally occur in real world events about which there is neither a Sartrean like existential choice nor responsibility. My philosophical understanding and beliefs have, for many years, revolved around there being more than one truth associated with a single life event. – To perceive only one unitary truth, I regard as a positivist, reductionist view which has little place in or value to the real world. An example I gave in my LA, related to my parents where my (step) father died from cancer at age 52 years (when I was aged 18) and my mother lived to the age of 99, having had cancer when she was aged 46. My experiential knowing is that people both live with and die from cancer; both realities are true. I believe in the real world, especially within my professional role as a psychotherapist, in honouring the integrity of multiple truths and equally the polarities of truths.

I cannot fail to have been influenced by life experiences; how it has shaped my understanding of the world. How I know what I know; the nature of my knowledge, Husserl's 'natural knowledge', and the justification for my beliefs. Part of the interest for me in this research, is the integrity of the psychotherapist and other professionals to honour the individual bereaved person's experience; to be open to all of their unique experience. Malraux's moving book 'La Condition Humaine' (Malraux, 1946) resonates for me today with Braud & Anderson's (1998) text, the subtitle of which is 'Honoring Human Experience'. It is this I wish to capture and promote in others through the dissemination of knowledge

about the wide range of human experience of loss and grief. I believe this will require others to look beyond their own theoretical orientation, cultural norms and practice base which make up the body of their already acquired knowledge. My challenge is for those working in a professional capacity with bereaved people, to adopt an epistemology that embraces the world of the bereaved, not merely the world of their profession. My specific challenge to bereavement counsellors is to allow relational encounter with the client's experience and adopt a transtheoretical approach which honours multiple truths and unique phenomenological experience.

Flick describes his epistemological position in reference to 'Schutz' (1962) concept of 'multiple realities', Ricoeur's (1981) three forms of 'mimesis', and Flick's (1995) concept of 'social representation' and 'making meaning of the world' (Flick, 2009: 85). In my LA, I placed considerable significance on multiple truths and the 'mimetic position', citing Riessman (2008) as a means of conveying the bereaved person's experience.

The thread running through my own ontological and epistemological position originates from experiential knowing and learning, both from my own and others' phenomenological experience, engendering a recognition and balanced acceptance of the individual and idiosyncratic nature of grief, resilience and growth. Such strong influences account for and serve as an explanation to what

could be perceived as conflicting theoretical perspectives in my therapeutic approach to bereavement work yet which I purport to represent a more balanced academic and emotionally intelligent argument. Thus, coherency is maintained with a non-purist and anti-schoolistic approach; one which advocates instead an epistemology of grief where the research is embedded in action research based on a methodology of four ways of knowing and learning.

Even so, I initially encountered theoretical challenges to my PC stance, feeling professionally conflicted and lacking conviction in my own orientation. I took a step back, reflecting on past delivery of first lecture material to PG Diploma students: Rogers in historical context. Cartesian dualism featured, offering a deeper understanding of the mind/ body split which generated the opposing philosophies between Freud and Jung. Significantly following Descartes' philosophical discourse, Freud reverted to the biological analytical frame whilst Jung made a distinct departure to analysis of the un/conscious mind.

Herein, lie fundamental links between the Jungian conceptualization of personality and Rogers' 19 Propositions for the development of personality:

> 'Collective thinking and feeling and collective effort are far less of a strain than individual functioning and effort; hence there is always a great temptation to allow collective functioning to take the place of individual differentiation of the personality.

> [] For the development of personality, then, strict differentiation from the collective psyche is absolutely necessary, since partial or blurred differentiation leads to an immediate melting away of the individual in the collective. There is now a danger that in the analysis of the unconscious the collective and the personal psyche may be fused together' (Jung, 1918; pars 239-240).

> 'XIV) *Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension'* (italics author's original: Rogers, 1951: 510).
> 'XVI) *Any experience which is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself'* (ibid: 515).

Both Jung and Rogers highlight the negative influence of external 'forces' upon individual development of personality, how the latter may be impaired and how an inauthentic self-concept develops to avoid psychological strain and tension. Likewise, both identify emerging negativity from such psychological tension; Jung in reference to neuroses and Rogers to anxiety and incongruence. Equally, they both posit individual growth which emanates from a deep internal process:

> 'Life is an energy-process. Like every energy-process, it is in principle irreversible and is therefore directed towards a goal. That goal is a state of rest [] which forever attempts to re-establish itself. Life is teleology *par excellence;* it is the intrinsic striving towards a goal, and the living organism is a system of directed aims which seek to fulfil themselves. [] Youthful longing for the world and for life [] is life's obvious

> teleogical urge which at once changes into fear of life, neurotic resistances, depressions, and phobias if at some point it remains caught in the past, or shrinks from risks without which the unseen goal cannot be attained' (Jung, 1938; par 798).

Recognizable within the PC ethos, philosophy and theory, is Jung's emphasis upon the teleological process, understood as the Actualising Tendency and Organismic Valuing Process, both inherent in the 19 Propositions (Rogers, 1951) and both key to PC practice linked to personal growth.

Acknowledgement of the pertinence of 'idealization' and issues of attachment in bereavement, equally derive from experiential knowing and learning from others. Denial of such salient aspects of the grief process would lead to failure in meeting the emotional and psychological needs of bereaved people. Working with such concepts are essential and whilst they became popularised through Freudian and Bowlby's psychoanalytic roots, I perceive them as belonging to human (and indeed, in varying degrees, to all mammalian) experiencing, and hence non-exclusive to psychoanalysis. It is the intrapsychic or intrapersonal meaning that holds significance for the bereaved individual and, like many, consider Bowlby's work on attachment and loss to be a seminal contribution to understanding the wide implications of loss and grief (Bowlby, 1980).

Having articulated how I fundamentally position myself and integrate differing theoretical paradigms into my own theoretical stance, I now turn to the literature review proper and the choices I made in selecting the various sources for examination and critical review.

2.4 Selected literary sources

Since my clinical practice is firmly underpinned by a non-pathologising, practice-based approach to grief therapy, it felt incumbent upon me to conduct a wide critical review of existing bereavement literature and to examine the clinically driven, pathologising perspectives that I knew to be universally adopted. Crucially therefore, an examination of the numerous diagnostic criteria and assessment scales was called for, these having been adopted by the medical, psychiatric and nursing professions, statutory services such as Social Work and many organizational and training institutions.

In reference to my own position as explicated above, of equal importance, literary sources and research studies which might illuminate the potential for personal growth despite major loss, grief and traumatic experiencing, even of a prolonged nature. Within this, a clear intention to conduct a search on the condition and phenomenon of Tinnitus since, over years of practice, I have encountered this physical condition as present for several bereaved individuals and for whom it has either dissipated altogether or greatly reduced following grief therapy.

In addition, given the frequency with which bereaved clients self-report trauma symptoms including debilitating panic attacks and intrusive imagery, I believe

there is a therapeutic value and gain in understanding how the brain processes traumatic experiences and why such events become involuntarily iterative in nature. Hence, I have selected authors whose text articulates neurobiological functioning in relation to implicit and explicit memory processes and how these replicate the therapeutic process between therapist and client. Emphasis rests with the therapeutic lens.

2.5 Initial searches to define the field of relevant literature

Databases were accessed via electronic search engines: Academic Search Complete, Athens, ASSIA, CINAHL Plus, Cochrane Library, MEDLINE, PubMed, PsychINFO (EBSCO), Science Direct (Elsevier), SwetsWise, Wiley InterScience. Of immediate interest, was the absence of medical research studies associated with loss in the context of bereavement. For instance the Cochrane Library showed no results which significantly highlighted a lack of recognition and acknowledgement in the medical field of the potential for bereavement to manifest as a physical or pathological condition or, a lack of recognition that the on-set of physical pathology can occur as a bodily response to grief.

2.6 Contextualising sources of bereavement literature

As stated, the corpus of work in the field of bereavement is immense and therefore my approach to this review is to contextualize clinical perspectives and

theoretical movement over time and how this has informed and influenced practice for those working with bereaved people.

Collectively, there is no dispute that loss and grief experiences are a universal phenomenon within both human and mammalian worlds in general. Studies of both have identified their impact on behaviour and expression of emotional distress of individuals and homogenous groups in different parts of the world. Opposing philosophies and practices fluctuate along a continuum between a purely phenomenological epistemology and approach, to scientifically driven, pathologising diagnostics which, broadly speaking, represent the qualitative and quantitative paradigms.

2.6.1 Validated tests and grief questionnaires

Several scientifically validated tests and self-report scales have been designed to assess levels of severity of an individual's grief or to identify specific symptomology, the most widely used are presented in Table 1.

Table 1

Scale	Author	Date	Type
Impact of Event Scale	Horowitz et al	1979	Study design of bereaved: Subscales of Intrusion and Avoidance; 15 Item
Texas Revised Inventory of Grief (TRIG)	Faschingbauer	1981	5-point Likert scale: typical and atypical symptomatology

Grief Experience Inventory (GEI)	Sanders, Mauger & Strong	1985	135 True or False Items e.g. I feel restless
Grief Experience Questionnaire (GEQ)	Barrett & Scott	1989	5-point Likert of 55 Items; tests frequency of grief reactions; includes suicidal bereavement
PENN Inventory	Hammarberg	1992	Following Piper-Alpha disaster; screening PTSD: 26 Item with caseness at 35 point cut off score
Inventory of Complicated Grief (ICG)	Prigerson et al	1995	5-point Likert scale of 19 Items Measurement of maladaptive symptoms of loss
Inventory of Traumatic Grief (ITG)	Prigerson, Kasl, Jacobs	2001	5-point Likert of 30 Items
Hogan Grief Reaction Checklist (HGRC)	Hogan et al	2001	Departure from quantitative to qualitative data collection on normal grief reactions
Adult Attitude to Grief scale (AAG)	Machin	2001	5-point Likert with 3 Subscales: Overwhelmed; Resilient/ balanced; Controlled
Terminally Ill Grief or Depression Scale (TIGDS)	Vyjeyanthi et al.	2005	42 item with subscales for Preparatory Grief and Depression to differentiate between the two in terminally ill patients
Prolonged Grief Disorder (PGD) – in DSM	Prigerson et al	2008	Separation Distress and Cognitive, Emotional Behavioural Symptoms Criteria

Although clinicians do peer review and critically appraise research studies, their psychometric properties and measurement outcomes, the genre of their critique conveys the essence of credibility, validity and reliability of the use of such

measurements; a general consensus to administer psychometric tests with bereaved people. Personally, I find this somewhat disappointing and question their applicability and usefulness to bereaved people and the therapeutic process.

Whilst constructivists Neimeyer and Hogan (2001) do identify the TRIG for its failure to identify symptoms of 'guilt, bitterness, performance disruption, and hallucinatory experiences' (2001: 95-96), their critique fails to address its banality. I posit that some items are too banal to give real insight and meaning into the bereaved person's experience, as exampled by a measurement item of *'At times I feel the need to cry for the person who has died'*. A Likert measurement for crying/ not crying neither measures in real terms the affective impact of the loss upon the bereaved person, nor gives meaning to the nature of their loss. Their criticism of the GEI points out 'trivial rewordings of the same ideas' (2001: 97) which I example with *'I tend to be more irritable with others'; 'I find I am often irritated with others'; I am often irritable'* thus accounting for 3 separate items, rendering two superfluous to the overall measurement. However, more specifically, my concern lies with administering a 135- item questionnaire (the GEI) to a bereaved person in the first instance and I question the therapeutic value in doing so. Despite Neimeyer's renowned authoring of phenomenological experience and social construction in bereavement, his critique suggests acceptance in the administering of such questionnaires.

My query over the use of such psychometrically validated measurements is twofold: initially the lack of consideration and sensitivity towards an emotionally vulnerable, bereaved person; secondly, the absence of diverse and unique experiences and emotional affect that get missed as the 'items' do not generate a coherent narrative; the approach favoured and promoted by those who stand within the qualitative phenomenological field. Neimeyer and Hogan (2001) support the use of qualitative methods:

> Because of their (qualitative studies) special congruence with a constructivist orientation, such approaches are ideally suited to reveal the unique meanings that inform the reactions of individuals or cultural groups to death and loss, thereby both broadening and deepening the scholarly study of bereavement' (2001: 110).

Contentiously, the citation below infers a contradiction to their above valuing of individual, uniqueness in bereavement, in their acceptance of a difference between traumatically bereaved individuals and those who have anticipated loss:

> 'A researcher might predict that traumatically bereaved individuals might show more fluctuation than survivors of expected loss, given the alternation of intrusive and avoidant symptoms in the former case' (2001: 111).

In this 2001 citation, they are referring to Horowitz et al Impact of Event Scale from 1979: an indication of the longevity of and continuing influence of dated scales and measurements. More so, this outdated distinction lacks awareness of more subtle complexities involved in anticipated loss, the dependent variables, that can only be revealed through the bereaved person's own narrative. The assessor needs a more sophisticated – or to use their term 'scholarly' – understanding to 'measure' the individual's bereavement. Professionals working with bereaved people and researchers frequently ignore the diverse nature of bereavement and the multitude of variables associated with an individual's loss, adopting the *etic* position over an *emic* approach (Prince, 2003). In doing so, they place emphasis upon the researcher's 'etic' discipline rather than the words of the bereaved.

Prigerson and Jacobs (2001) promote traumatic grief as a distinct disorder and suggest it is a syndrome 'similar to chronic grief' (2001: 633) with future studies possibly identifying a link with inhibited or delayed grief. I struggle to understand the report items in the ITG as predictors of traumatic grief and cite 3 items below:

3 'Memories of _____ upset me'.

11. 'Ever since _____ died I feel like I have lost the ability to care about other people or I feel distant from people I care about.'

28 'I believe that my grief has resulted in significant impairment in my social, occupational or other areas of functioning'. (Prigerson and Jacobs, 2001: 638 – 644).

These and all other items are highly prevalent for the majority of bereaved individuals who ought not to be regarded as having a disorder based upon sum scored criteria to measure severity. I believe there are risks to the bereaved in such prescriptive measures: a pathological view of the client and 'caseness' for traumatic bereavement being decided by a numerical score rather than the client's phenomenological and intersubjective experience. In similar vein, Stroebe and Schut (2001) query Horowitz's intrusion-avoidance assessment as symptoms of the severity of traumatic impact, leading to a pathologised view of the person based on a clinical case/ non-case cut off point. In opposition to Horowitz, they see intrusion-avoidance as a non-pathological coping strategy and point out that Horowitz's measurement does not account for multiple stressors such as finance and attachment issues resulting from the bereavement. Neimeyer and Hogan (2001) levy a similar criticism at the BDI (Beck, 1990) claiming it is a psychiatric measure which is non-specific to bereavement and does not contain psychosocial aspects of grief including attachment issues of distress. I believe this supports my argument that proven scientific reliability and validity of psychometric tests can neither be ascribed nor generalized to a bereaved population. Yet, the BDI is regularly used to identify depression in bereaved people, as are PHQ-9 (Appendix

4) and GAD-7 (Appendix 5) within current IAPT services for depression and anxiety respectively. IAPT referrals to WBS now come with reference to scores from GAD-7, PHQ-9 and HADS (Appendix 6). I find this extremely disconcerting as these are intended measurements for psychopathology, not an assessment for bereavement. None of these measures are commensurate with the psychosocial factors, the neurobiological and subsequent physiological responses of individuals when bereaved through major and/ or traumatic loss.

Recently, I was informed of a bereaved NHS patient's distress having been asked to complete the psychometric tests GAD-7 and PHQ-9 which are currently in vogue within IAPT services Cheshire and Wirral NHS Foundation Trust (NHS, 2009). The patient's expectation had been bereavement counselling relating to an elderly parent's recent death; a need to talk about the distress and impact of the loss upon daily functioning. This patient had no prior mental health history, did not feel 'met' by the assessment process that took place and indeed left in yet greater distress. The need to meet bereaved people at a relational level in the 'here and now' cannot be overstated.

Self-report scales continue to be used and revalidated through meta reviews of later studies with bereaved populations such as the HADS (Mykletun, 2001), IES (Sundin and Horowitz, 2002) and the PENN Inventory (Hammarberg, 2005). Clinicians have continued to debate and empirically evidence further

measurement and diagnostic criteria to assess what they regard as abnormal grief response, referred to as pathological or complicated grief.

2.6.2 Assessment for pathological or complicated grief

Horowitz, Bonanno and Holen (1993) recommended inclusion within DSM of pathological grief criteria based on personality type descriptions of abnormal responses to loss. They proposed a predictive model formulated on 'antecedent trait combinations' (1993: 1) based on personality and character traits of the individual as opposed to circumstances of 'unsuccessful mourning processes' (1993: 1). Later, a study with 70 bereaved spouses conducted by Horowitz, Siegel, Holen, Bonanno, Milbrath and Stinson (1997, Horowitz et al., 2003) led to a new diagnosis of complicated grief disorder (CGD). Despite caution against the revision of diagnostic criteria based upon existing disagreement between clinicians (Stroebe et al., 2000), CGD nevertheless found its way into DSM- IV TR (APA, 2000). Their criteria, founded on the basis of their descriptions being none other than normal and rational grief responses, these being:

> 'current experience (more than a year after a loss) of intense intrusive thoughts; pangs of severe emotion; distressing yearnings; feeling excessively alone and empty; excessively avoiding tasks reminiscent of the deceased; unusual sleep disturbances and maladaptive

> levels of loss of interest in personal activities' (Horowitz et al, 1997: 904).

Szanto et al (2006) claim that 'complicated grief is associated with increased suicidal ideation in samples of bereaved individuals' (2006: 233). Complicated grief is not a predictor of suicide ideation and suicide ideation in bereavement is not restricted to complicated grief. It is, in effect, a normal manifestation of grief within early months of wanting to still be with the person who has died and as such is to be distinguished from a client's actual, real and true desire for their own death. It is, however, true to say that if a bereaved person persistently maintains suicide ideation over a prolonged period of time, there is an increased risk this will be acted upon and/ or could become a debilitating factor in their on-going life.

The Prigerson et al (2009) study validated psychometric properties for yet a further diagnosis of Prolonged Grief Disorder (PGD) to replace the existing CGD for the new editions of DSM-V (later 5) and ICD-11. Five out of a possible nine daily symptoms were established as criteria to be met for diagnosis of PGD (Appendix 7) which, again, I identify as normal grief reactions. If these symptoms have not started to decrease at the second anniversary death, perhaps there may be a case for prolonged grief however, to diagnose as a disorder is questionable. To do so at such an early point in a person's bereavement, is not clinically sound

and PGD became a highly contentious and contested issue resulting in the BPS withdrawing its affiliation to the APA, disapproval from the British Medical Association and Counselling and Psychotherapy profession:

> 'We are questioning the Task Force of the American Psychiatric Association's decision to include **'grief' as a diagnostic category** in its forthcoming DSM-V. This is one of a number of examples of the medicalisation/ pathologisation of the ordinary human condition' (Samuels, 2010).

Boelen and Hoijtink (2009) open their research paper with 'Some people confronted with the loss of a close relative develop emotional problem' (2009: 101) and, citing Prigerson et al, evidence their allegiance to a concept of grief 'disorder':

> 'CG is a disorder that encompasses grief-specific symptoms including yearning, disbelief regarding the death, pre-occupation, and recurrent images of the lost person that occur for at least 6 months, to the point of functional impairment (Prigerson, Vanderwerker, & Maciejewski, 2008)' (Boelen and Hoijtink, 2009: 102).

I find it quite incomprehensible that clinicians are so ready to diagnose a person as ‘disordered’ and having mental health problems as a result of a bereavement within the past two years, let alone six months. I do question the extent to which clinicians are intent upon establishing bereavement disorders merely to have entries placed in the diagnostic manuals with predictive criteria based on a factorial structure as a global measurement. Controversy regarding the proposed PGD diagnosis for DSM 5 (2015) continued and although it was not entered, the former exclusion clause of bereavement that had been applied to Major Depressive Disorder, was removed, thereby creating potential for a bereaved person to be given a psychiatric diagnosis of MDD.

Some clinicians were preoccupied with scientific evidence for future prediction. Prigerson et al (1997) proposed a symptomatology focus for the prediction of future ill health (mental and physical) resulting from traumatic grief. An analysis of their study identified a sample of 150 drawn purely from a future widowed/ widower client population, all of whom were initially interviewed at the hospital admittance point with follow up at intervals up to 25 months. I seriously question their conclusions of risk for long term dysfunction and mental and physical morbidity based on findings of traumatic grief symptoms at six months after the death which they claim predicted medical conditions, suicide ideation and changes in eating habits. Again, these symptoms fall within normal grief

reactions following the death of such a close loved one and life partner. Their results are not transferable to all bereaved age groups, nor to multiple causes of bereavement. Indeed, the results may well have been confounded (Prince, 2003) by natural ill health variables of the participants and their own aetiology which was not factored in as a dependent variable.

Such prescriptive 'models' are at risk of a) missing individuals whose pre-loss personality and character would not predict a tendency for traumatic or complicated grief and b) underestimating the potential nature of traumatic loss to lead to a pathological state/ heightened psychological distress/ arousal and c) fails to acknowledge that a traumatic response is normal to abnormal situations. This only creates a further clinical chasm in the recognition of chronic and traumatic bereavement, a chasm which develops from clinical interpretation: whether a bereaved person has or has not a psychological disorder resulting from the manifestation of their grief. Zisook and Shear (2009) established that psychiatrists are not always able to identify complicated grief due to inaccurate assumptions that time heals and through neglect of the disabling and longer term impact of chronic grief. Psychiatry draws heavily on DSM within which there are differential diagnoses and definitions for overlapping symptomatology, amongst which personality and character traits abound, along with depression and anxiety disorders. Interpretation of criteria and differential diagnoses is used to identify a person's mental health and I contend that adding further to the corpus

of diagnostic criteria is not the answer to understanding a person's bereavement. A strong counter argument to the classification of pathological grief has been levied on the grounds of 'a lack of critical evaluation' (Stroebe et al., 2000: 57) of existing diagnostic criteria accompanied by a call for an evaluation of the ramifications of such a diagnostic status of pathological grief (Stroebe et al, 2000).

2.6.3 Considerations of complex grief

The development of the above diagnostic criteria did not factor in key dimensions to an individual's grief process, nor the complexity of it, missing the essential meaning of their loss to them and its impact which would give insight into the therapeutic work to be done. Psychological distress caused through grief is best addressed from a position of understanding the complexities involved rather than a pathological description (Thompson, 2012). Life experiences giving rise to complex grief are known to be wide ranging:

> 'Multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence, have consistent and predictable consequences that affect many areas of functioning. These experiences engender intense affects, such as rage, betrayal, fear, resignation, defeat, and shame…' (Van der Kolk, 2008: 54).

Here, Van der Kolk is referring to Complex Trauma and specifically to the more recent understanding of developmental trauma from childhood experiences. Therapeutic work with bereaved individuals frequently encounters such phenomena of this nature which is entwined with their grieving process and attachment. Earlier traumas can promote in adulthood, an 'idealized attachment' (De Zulueta, 2008: 62) to maintain an [acceptable] attachment through 'idealised versions' (ibid), thereby retaining hope in the future. When someone dies, the opportunity for a better relationship is gone forever and the intolerable sets in, evoking excruciating pain. Attachment related trauma often resides within the grief process, irrespective of physical or sexual traumatic experiences: a symbiotic relationship; being a 'looked after child' or a boarding school child; a carer and so forth. Equally, a traumatic loss or death can be either a physical event or a purely emotional experience, both initiating physiological and visceral responses.

Consideration of the relationship between mind and body has taken a far higher profile in recent decades, spearheading a move away from a focus on the debilitating symptoms of PTSD to an understanding of the relational therapy involved with trauamtised clients. Etherington (2004) asserts that through telling stories, personal strengths and resources can be uncovered which were previously unknown or hidden from the client and in this way, the trauma becomes

transformed. Transformation from trauma is a relatively new concept which draws upon mind-body science: somatic experiencing and listening to our bodies, 'to think and feel concurrently' (Rothschild, 2000: 161); Levine in interview – 'energy being released that's shifting from one system to another' (Yalom & Yalom, 2010: 5); 'symptoms are the key to healing trauma' (Giarretto, 2010: 2); resilience and robustness (Joseph, 2008). Van der Kolk's paper on 'The body keeps the score' (1999) and Rothschild's 'The body remembers' (2000) have influenced and informed later authors and practitioners.

Of interest, here, is the view that following a trauma, homeostasis is not regained but rather, 'allostasis' creates stability with a **new** "set point" and 'a new level of system regulation' taking place (Wilson and Thomas, 2004: 214). They further assert:

> 'Empathic attunement and high empathic functioning are essential to facilitate transformations from one psychobiological state to another' (Wilson and Thomas, 2004: 214).

2.6.4 Post bereavement growth

The concept of a new 'set point' links into the pioneering work of Calhoun and Tedeschi (2006) into Post Traumatic Growth (PTG). Likewise, Joseph and Linley on positive psychology and the concept of growth in the face of adversity, the prevalence of which they evidence in practice through several research studies: (Linley et al., 2003, Linley et al., 2007a, Linley and Joseph, 2005, Linley et al., 2004, Joseph, 2004, Linley et al., 2006, Linley et al., 2007b, Linley et al., 2008). Joseph emphasizes that personal growth originates from 'their cognitive struggle with the event and its aftermath' (2015: 188) and equally, promotes caution as 'Adversity does not lead to positive change for everyone' (ibid). Here, the premise from Neimeyer and Hogan (2001), and Schwandt (2003) who posit a constructivist epistemology where no single, universal or absolute truth can be asserted, serves as a sober reminder to practitioners working with bereaved people that not all will emerge from a grief process in a growthful way.

Conversely, however, personal robustness and resilience is evident in many and, absent from diagnostic material presented earlier, bereavement phenomena also identifies improved quality of life and psychological well-being. For example, a long period of intense mourning for bereaved people whose lives have been dominated by caring for a chronically or terminally ill loved one – and all the emotional distress and pain that usually accompanies such situations – can be followed by relief and a sense of liberation. I recall several clients where the focus

of their grief therapy lay in helping them to regain a life for themselves as valuable individuals who wished to enjoy life again as exampled by a few below:

Table 2

PBE: Evidence of Post Bereavement Growth

Cause of Bereavement:	**Post Bereavement Growth:**
Husband died after retirement	Took up line dancing and holidays abroad for the first time
Teenage daughter died after years of being cared for at home and kept alive by life supporting equipment.	Trained for a new career
Very young child, cared for at home, died from congenital condition	Parents re-invested in their own relationship and lives
Husband died young by suicide	Started own successful business
Husband died young by traumatic accidental death	Became a 'partner' in legal firm, bought new apartment and entered new relationship
Wife, father-in-law and brother-in-law died by tragic accident	Developed a creative and successful business and started to become open to a new personal relationship
Husband and 3 children died in Road Traffic Collision (RTC)	Became involved in local politics and charitable works from which a social life developed.
Long term lesbian partner of 20+ years died; had lived apart as secret relationship	Sexuality publically owned; social life ameliorated, improved psychological well-being and hope for future.

2.7 Relational bereavement work and neurobiological underpinnings

Notably, there is a gap in the existing published literature regarding relational therapeutic encounter with bereaved people in relation to neurobiological functioning. My intention here is to locate and underscore clinical aspects pertinent to bereavement work within a neurobiological understanding and

theoretical frame for psychotherapeutic work. I believe this to be a developmental element within the field of bereavement to critically enhance the effectiveness of psychotherapeutic intervention with the inclusion of a neurobiologically informed knowledge base. In the world of the bereaved, obviously memory plays a highly significant role. Essential therefore, for bereavement training to include information which aids clinical understanding to inform practice. An obvious statement, however, little attention has been paid to memory from this perspective in bereavement literature.

2.7.1 Memory

Drawing on the work of Siegel (1999) and the differentiation between semantic and episodic memory, the process of autonoesis and the implications of 'attractor' states and there being no spacio-temporal quality in the amygdala, provided the lens through which the aspect of memory was delivered in the training, incorporating also Walby's (2003) discourse on complexity theory and its non-linear relevance to memory.

Within this neurobiological framing of memory, the recognition and concept of 'cumulative grief' becomes more explicit and meaningful in relation to bereavement when the word bereavement is understood as representing all the individual's experiences over time that are connected to loss and grief. The 'ruche' metaphor I use in training to create a visual image of a cumulative grief process, offers the trainees insight into the potential impact of recursive patterns

from earlier loss and grief experiences which is likely to inform the client's current grief process and also how they imagine life to be for them in both the immediate and longer- term future. This can of course be either a positive or negative influence, depending upon the nature of the individual's past experiences and emotional response states: the content of their autonoetic consciousness and the somewhat magnetic pull into 'attractor states'. My premise is that this neurobiological understanding offers an explanation as to why some people cope amazingly well with an incredible history of loss, demonstrating resilience and robustness to come through yet another major loss in their life. Yet, others encountering a major loss for the first time in their lives may report an inability to cope and represent themselves as completely 'broken' and without a future. These are opposite extremes whereas, of course, there is a continuum of potential experience in relation to multiple loss and how it can manifest. Training content of this nature has been crucial in supporting bereavement counsellors working with clients who have multiple loss in their lives.

2.7.2 Relational working and neurobiological resonance

The significance of a relational dimension within the therapeutic relationship to therapeutic outcome is now universally accepted across multiple modalities. This is evidenced in theoretical orientations from Integrative Psychotherapy (Clarkson, 2003), Cognitive Behavioural Psychotherapy (Gilbert, 2007), Transactional Analysis (Hargarden and Sills, 2002), EMDR (Dworken, 2005),

Person-Centred (Knox & Cooper, 2015) and Relational Psychoanalysis (Maroda, 2009). The latter today, as a relational and intersubjective approach, was a radical departure from the purist approach that favours the tradition of 'frustrating' the client as opposed to resonating with the client's emotional states and, so much so, that Maroda's text was refused publication in the US. Whilst evolving as a theory in the latter part of the twentieth century (Mitchell and Aron, 1999), at the turn of this century, Fonagy wrote:

> 'Its identifying tenet is perhaps the assumption that the psychoanalytic encounter is co-constructed between two active participants with the subjectivities of both patient and analyst contributing to generate the shape and substance of the dialogue that emerges' (Fonagy, 2001: 123).

The emergence and challenge of relational psychoanalysis is therefore of considerable interest to the psychotherapy field, supporting the more widely accepted perspective that the therapeutic relationship is recognized and accepted as an essential core ingredient for effective therapeutic outcome (Cooper, 2008). Interestingly, long before any of the above mentioned authors, Clarkson (1995) wrote the first edition of her seminal text, 'The Therapeutic Relationship' and long before that, Rogers initiated a radical departure from the psychological medical model to emotionally meet patients in an empathic relationship. His combined six conditions are representative of the relational dimension within the

neurobiological frame that is required to achieve bilateral resonance and integration. I do not believe my link of Rogers' psychotherapeutic model to neurobiological functioning is a provocative or contentious statement to make. Indeed, a significant tribute by neuroscientist Cozolino attests to its plausibility:

> 'Rogers may have described the best interpersonal environment for brain growth during the development and change in psychotherapy' (Cozolino, 2002: 52).

Significance for the importance of resonance and attunement, has been further supported by Gilbert's research, jointly conducted in America, using MRI scanning of the brain to monitor and plot neurobiological activity during therapeutic intervention. The outcome presented at BACP Conference by Gilbert (2009), clearly evidenced neurobiological resonance when the [client] experienced the therapist's attunement and 'compassion'. I do take serious issue with Gilbert on his directional move from CBT to CFT theory without respectfully referencing to other modalities whilst paradoxically 59ecognized59 its contribution to the increasing universal acknowledgement of the quality of the therapeutic relationship. Unfortunately, his introduction as the day's keynote speaker included information that he would not be taking questions after his address but would talk for the full period of time. Considering he was presenting a 'new' theoretical model and indeed promoting from the podium his newly established training in this method, I found it quite frustrating and startling not to

have the opportunity to ask what ameliorated psychotherapeutic benefits CFT had to offer above other humanistic orientations.

Conversely, the first (Freudian analytic tradition) keynote speaker, Fonagy (2009), presented an address on common factors and effectiveness of diverse psychological therapies in reference to mental states and mentalization occurring through a highly relational, emotionally secure and empathically attuned approach which could almost be compared to Gerhardt's (2004) book on the significance of the brain to love, bonding and secure attachment.

Specifically referring to the therapeutic endeavor, Siegel highlighted in greater detail the significance of bilateral resonance between the left and right brain hemispheres to promote therapeutic attunement and the client's secure attachment with the therapist:

> '(…) secure attachment involves an intimate dance of resonant processes involving left- to-left, right-to-right and bilateral-to-bilateral communication. This highly complex form of collaborative communication allows the dyad to move into highly resonant states' (1999: 334).

He further describes bilateral importance as:

> ‘*The left hemisphere’s drive to understand cause-effect relationships is a primary motivation of the narrative process. Coherent narratives, however, require participation of both the interpreting left hemisphere and the mentalizing right hemisphere. Coherent narratives are created through inter-hemispheric integration’* (1999: 331). (Italics in the original text)

Siegel employs a ‘mentalizing’ concept to describe the affective states located in the right brain whilst Heron refers to a process of ‘mentation’ (1998: 67) which he considers to be ‘processes of imaging and thinking’ (1998: 67). Heron’s use of mentation describes the bilateral process, the outcome of which he sees as subjective enactment: ‘My imaginary enactment becomes transformed by what it calls forth and meets’ (1998: 67). In effect, Siegel and Heron identify the same process using different terminology.

Such terminology around mental representations and therapeutic intersubjectivity has persistently prevailed within the field of psychotherapy and become increasingly associated with effective relational therapy practice. I align this to the ‘growth’ process for the client, acknowledgement of which has promoted a transcendence from elitist, schoolistic, theoretically driven practice to embrace

the more reflexive, moment-to-moment sessional process (Levitt et al., 2006; Fonagy, 2009; Knox & Cooper, 2015).

Literary and research support for the concept of client growth is now substantive and beyond the remit and scope for this literature review. Here however, growth in respect of trauma, traumatic experience and (traumatic) bereavement remains pertinent to this study alongside the relational, 'mentalizing' approach to promote bilateral resonance and integration in grief therapy work. Not infrequent for recently bereaved people, is the (re)emergence of past childhood and/or adult traumas following a recent major loss event, as evidenced within my own practice based evidence (Lebow, 2006), and which can be extremely diverse in nature: early abandonment through foster care, child sexual abuse/ exploitation, domestic violence (witnessed or personal experience), cancer diagnosis and treatment (witnessed or personal experience), rape, disaster experience (NY terrorism 9/11 (2001); Paddington train crash (1999); London July 7th (2005) bombings). Within my own training, the clinical perspective of growth has proved to be an invaluable resource for the therapeutic endeavor, concerning post traumatic growth (Calhoun &Tedeschi, 2006; Joseph & Linley, 2008; Joseph, 2011; Joseph, Murphy & Regel, 2012; Joseph & Murphy, 2013).

Bromberg's (2011) relatively recent work on trauma and relational working has further highlighted its significance to therapy outcome as well as adding to the

existing corpus of work. In specific reference to the grief process, his contribution on 'self-continuity' is of particular importance, stating that 'self-continuity is impaired if mental representation lacks robustness' (2011: 185) resulting in emotional instability. He claims:

> '[The bereaved] become unable to sustain the loss of a needed "other". It is these people for whom the potential for annihilation dread is often greatest. For them, the experience of loss can become such a threat to the experience of self-continuity that it results in what we know as insanity' (Bromberg, 2011: 180).

He continues to explain further:

> '[They are] unable to use an *imagined* other to heal the loss because imagination even in grief requires the simultaneous existence of a separate self that is stable enough to remember a lost other without merging with her' (2011: 181-182).

The thrust of Bromberg's work places the relational approach at the heart of therapeutic work to facilitate 'intrapsychic negotiation' (2011: 149) to promote a 'coherent sense of "me" (ibid) and this he links with the significance of

‘unanticipated relational occurrences’ (2011: 56) creating therapeutic growth in the space between client and therapist.

Relating Bromberg’s work to bereavement practice, the impact he highlights is recognisible in bereaved individuals. Indeed, I have encountered several clients for whom fear of annihilation is their reality following the loss of a partner, spouse, twin sibling, and child. In such cases, attachment trauma (Straker, 2004; der Kolk, 2008; de Zulueta, 2008) needs to be clinically recognized by the therapist: it is insufficient to work with popularized, traditional theoretical models of grief. Here also, consideration of relational trauma and broken bonds of attachment becomes equally significant in understanding the neurobiological impact on ‘affect regulation’ and ‘dysregulation’ (Schore, 1994; 2003; 2012).

In reviewing these clinical perspectives however, and though not generally naïve, I remain shocked and even appalled at a level of plagiarism I’ve encountered in credible authors’ failure to acknowledge and reference to Roger’s pioneering, clinical and theoretical work. Is this intentional or sheer ignorance about PC theory and Rogers’ 19 Propositions on the development of personality (Rogers, 1959) In support of this view, I example the most direct ‘take’ which, co-incidentally, I cited on page one of my introductory chapter:

> ‘In order for unprocessed subjective experience to become symbolized in conscious awareness …’

(Bromberg, 2011: 79, citing Kihlstrom (1987) quoted by Le Doux, (1989)).

2.7.3 Trauma and neurobiological functioning

In order to acknowledge the impact of a physically traumatic death, the trauma paradigm needs to be addressed. This involves neurobiological functioning which takes account of the physiological, psychological, emotional and contextual dimensions present and activated on the occurrence of a traumatic event. I have found that the grief process is not fully expressed by a bereaved person until any traumatic material has first been processed, necessitating a greater depth of knowledge of traumatic experience and consideration of the trauma experience has been useful to practice.

Since the amygdala is the location which activates autonoesis, it follows that the feelings of shame and guilt which often accompany traumatic experience (McNally, 2003; Etherington, 2004; Mollon, 2005) are also activated in the amygdala. However, autonoetic consciousness requires the bilateral integration with the hippocampus in the left brain in order to make sense of and be recognized as a unique specific event. Cozolino explains it thus:

> 'The amygdala has a central role in the emotional and somatic organization of experience, whereas the hippocampus is vital for conscious, logical, and co-operative

social functioning. Their proper functioning and mutual regulation are central to normal functioning' (2002: 96).

Rothschild (2000) refers to this as a bridging process:

> '… the implicit and the explicit must be bridged in order to create a cohesive narration [] to place them (memories) in their proper slot in the client's past' (Rothschild, 2000: 161).

Cantor captures this with his term 'agonic switch' and asserts that:

> 'The costs of the agonic switch are greater in hedonically orientated species such as ourselves, especially in present times' (Cantor, 2005: 182).

And further states:

> 'Peaceful existence is associated with the hedonic mode. Threats activate agonistic behaviour' (Cantor, 2005: 189).

Such a switch from hedonic to agonic mode is present following traumatic death and bereavement experiences. By way of example, witnessing death scenarios and life- threatening situations of loved ones, 'self' and strangers are frequently the substance of bereavement work for the therapist and are the DSM IV TR (APA, 2000) criteria for the definition of trauma. Such scenarios involve road

traffic collisions (RTC's), murder, suicide and accidental death all of a traumatic nature which often equally activate shame and guilt responses. Within my practice (PBE), I have encountered many such instances and also where a traumatic reaction to a previously life -threatening situation to 'self' has emerged for the first time in a client, triggered by a recent loss. Psychological trauma from earlier cancer diagnosis and treatment is prevalent in this regard, as are child sexual abuse, domestic violence, abandonment and rejection in childhood. Previously unaddressed loss and grief reactions also commonly emerge including pregnancy terminations accompanied by a heightened sense of guilt and shame.

Inherent in the above practice examples, lay the concepts of delayed PTSD and complex PTSD which has its roots in earlier childhood trauma. Cantor (2005) sees complex PTSD as a qualitative developmental disorder. Whilst I concur with his humanistic stance of it being qualitative in nature, I prefer to use the term developmental deficits rather than perceive it as a disorder. Deficit is more appropriate to the psychotherapeutic process inherent in bereavement work and is the stance to be promoted in bereavement training. Current trauma from a Jungian perspective, supports my approach:

> ' [ ] the most recent edition of a much earlier trauma – one that she had not been able to experience - (later) she could start to grieve the loss of those childhood years' (Kalsched, 1996: 46).

Since psychological trauma frequently emerges in bereavement work, it is essential for therapists to be alert and equipped to work with its onset, whether immediate or late. This necessitates acknowledgement that later traumas compound earlier traumatic stressors which have not yet reached autonoetic consciousness, thereby remaining cognitively unprocessed and therefore are open to agonic arousal. A useful understanding of delayed PTSD is seen as:

> 'A protracted asymptomatic state followed by a life stressor that triggers overt PTSD, the original trauma response being subthreshold for diagnosis [] with symptoms increasing over time' (Cantor, 2005: 30).

Here however, I suggest a different dimension to traumatic experience in the bereavement field where subsequent circumstances add considerably to the initial traumatic event. This may involve for instance the outcome of a Coroner's inquest and report, how information of a death was delivered, or subsequent visual imagery. Rothschild refers to this as 'the aftermath of trauma' (2000: 156) and posits that 'the aftermath of trauma can wreak even greater damage' (2000: 157). Again, examples from my own practice include instances of bereaved individuals returning home alone from hospital to a bathroom or bedroom almost saturated in blood, with subsequent on-set of PTSD symptoms.

Cantor (2005) adopted an evolutionary approach to trauma which, similar to that of constructivism, allows for historical and contextual change. His premise is that crime or malice related trauma results in higher rates of PTSD symptomatology and he links this with the evolution of the triune brain and how human (defensive) behaviours have evolved over time. I frame Cantor's evolutionary theory within a contemporary socio-political dimension of trauma, stress and PTSD whereby traumatic stress is surrounded by political argument and derision. Politics of trauma in the psychotherapy field is concerned with perceptions and contextual determinants, frequently debated within legal systems to prove and discredit the validity of insurance and compensation claims for PTSD. Further, the terms victim, perpetrator and survivor are highly political (Herman, 2002; Hassan, 2003; McNally, 2003) and hence controversial terms. Neuroscience has gone some way to redress the previously scant clinical data evidencing neurobiological functioning in emotional impact (Freed and Mann, 2007), (Wang et al., 2007) however, political power often dictates. Whilst a fascinating area of inquiry, I must restrict comment to the focus of my research whereby the bereavement therapist may be required to produce written evidence for court cases involving medical or police negligence, traumatic stress or PTSD for employers, housing or unemployment benefit. To serve the client well, the therapist must demonstrate professional theoretical knowledge and clinical competency which has credibility in institutional and legal systems: knowledge is power (Foucault, 2004). Regardless of theoretical orientation, I therefore argue that

neurobiological functioning needs to form part of the therapist's knowledge base with an equal view to cautionary and ethical practice (BACP, 2016).

Herman (2002) refers to the vulnerability of clients with somatic, dissociative and affective mood sequelae whilst Rothschild (2000) refers to applying the brakes when working with traumatized clients and although EMDR seeks to process trauma through 'sensory, cognitive, neurobiological, and physiological aspects' (Mollon, 2005: 241), EMDR training insists upon ceasing the bilateral stimulation if the client starts to be re-traumatised by the process.

The prevalence for traumatized individuals to have no conscious memory of events is acknowledged in the field. Mental representations (in consciousness) of the traumatic experience are greatly resisted in psychological trauma in an effort to avoid emotional pain and anxiety. Such defensive avoidance implicitly means the experience remains 'undigested' (Shapiro, 2004) which Mollon (2005) interprets as a resistance to processing. When training, I reframe this as an important survival strategy which has served the individual well and which needs to be acknowledged and prized in therapy rather than stripped away from the client in the therapist's pursuit of healing and healthy integration: it has, after all, been a strategy to control agonic high arousal and maintain homeostasis. In similar vein, the primitive defenses of 'idealisation', 'de-personalisation' and 'psychic numbing' (Kalsched, 1996: 2) are survival strategies. Of particular value to the field is Kalsched's positive view of such strategies and his critique of

traditional psychoanalytic thinking which regards such defenses as symptoms of severe psychopathology. His view is of their 'life-saving sophistication' (2005: 2) which is neither universally acknowledged nor always given credit and perceived as a strategy for preservation.

McNally (2003) asserts that people are often reminded of disturbing events long after the event occurred and repression and dissociation are common responses to trauma (McNally, 2003; Etherington, 2004; (Warner, 2005). Certainly, this has been my experience of clients however, I challenge his concept of a 'dose-response model of trauma' (McNally, 2003: 79) where the duration and frequency dictate the severity of the trauma impact. I concur that lengthy exposure to a trauma and high frequency do contribute to the severity of PTSD symptoms however, it does not necessarily equate that minimal exposure or a single occurrence indicates lesser traumatic responses. Further, a dose-response model does not take account of the many variables and antecedents of a person's life experience and as such I contend severity of trauma is not predictable in this way.

Indeed, the clinical impact of experiencing an event as traumatic, remains unpredicatable and is not always easily recognized or acknowledged. In the course of my practice, I have been intrigued and curious about the manifestation of a physiological phenomenon which I believe to be associated with attachment issues and traumatic loss and grief. I further believe it is a much under reported

and under researched area simply because the medical and clinical world underestimate the impact of grief with bereavement being a natural phenomenon.

2.7.4 Tinnitus: a psychosomatic response to chronic and traumatic loss

Reference to the psyche-soma and psychosomatic nature of physical ailments has already been made. However, I have noted a total absence in existing literature of any connection between tinnitus and grief: using nine search engines and the search terms ‘tinnitus’ and ‘bereavement’, yielded 18,607 results separately but with a zero record for the two terms combined. The Cochrane library identified 57 studies and although stress figured highly, bereavement and grief were absent.

Prolonged Grief Disorder (PGD) intended to replace Complicated Grief Disorder as a diagnostic category, and resulting from studies conducted in grief and psychological distress (Prigerson et al., 2009), did not even consider possible impairments to health and quality of life to physiological conditions. Embodiment of psychological distress is not a new concept as evidenced by van der Kolk (1999), Rothschild (2000), Horowitz (2001), Levine (1997) and Gudmundsdottir (2009). Yet clearly no direct link has been made with nor empirically evidenced to the debilitating condition of tinnitus.

I present below a *Table* of empirical evidence which does identify a psycho physiological direct link between chronic and traumatic grief and the on-set of

tinnitus between six months and two years following the death of a close loved one.

Table 3

Evidence of the On-set of Tinnitus Following a Major Loss

Source	Ethnicity	Gender	Age at On-set	Period of Tinnitus
Colleague whose mother died when aged 5 years	WB	F	5 years	45 years and on-going; no therapy
Colleague whose brother died in his teens	WB	M	19 years	20 years and on-going; no therapy
Trainee with early major loss	WB	M	25 years	10 years and on-going; no therapy
Trainee whose grandmother died	WB	F	30 years	9 months and on-going; no therapy
Client whose husband died	Asian	F	45 years	10 months; severe psychological morbidity & no decrease in T. with therapy
Client whose brother died early, suddenly, unexpectedly at home in Africa when client was visiting. Client lives UK.	BA	F	46 years	2 years; ceased with bereavement therapy
Same client with second, unexpected family death in Africa	BA	F	51years	3 months; ceased with bereavement therapy
Client whose husband died suddenly	WB	F	56 years	4 years; ceased with bereavement therapy

Trainee with major loss and later, father's death	European	F	Mid 50's	37 years; losses in1980 decreased, then increased after father's death.
Client whose husband died	WB	F	68 years	11 months; decreased dramatically to minimally in 1 ear, after bereavement therapy

Although this sample size is small, the data remains of interest as in each case the on-set of tinnitus followed the death of a significant loved one. Further, in most of the groups I've taken since introducing diagram GED3 into the training, there has been one and sometimes two participants whose friend or family member developed tinnitus subsequent to a bereavement, this in addition to the three trainees who personally had the condition. Equally of interest, is the younger age range for whom this was reported which concurs with the above empirical evidence. Others' reporting of tinnitus cases also concurs with my practice knowledge of instances of sudden, unexpected, early deaths which are predominantly experienced as traumatic by bereaved people or, the intrapsychic meaning of the loss to the individual is traumatic.

An Asian client reported in a session of two other extended family members known to her who had also developed tinnitus in widowhood. However, they had

kept it a secret for fear of stigmatization of being regarded as mentally ill within the Hindu community. My professional opinion is that non-reporting of tinnitus is in fact extremely common as for most people it is not sufficiently debilitating to prevent normal daily functioning or a successful career. Moreover, I have yet to meet someone who has made a link between their tinnitus of many years and a previous tragic bereavement; they do not associate their physiological condition to grief. Barbra Streisand is a possible point in case who stated in a rare interview that she had suffered with tinnitus for many years, having always had it, as far back as she could remember – a fact which annoyingly I cannot support with a reference! However, it is known that her father died when she was 15 months old. As with other sufferers, it is important to note that the condition was not debilitating to the extent of impeding a successful career, nor engagement with life in general.

Below, a contribution from a research participant:

> I had the opportunity to share my own experience directly with you Anne during my training in 2010 when the subject of Tinnitus was approached. I first developed Tinnitus in 1980 following a move involving several losses. I saw my GP and a specialist, and both were unable to find any physiological explanations for my condition. The Tinnitus lessened over the years but never disappeared. Interestingly, it worsened again shortly after the death of my father in 2013. It was after the training, so I was not able to share this with you. My GP ordered a CT scan and, once again, nothing abnormal was found. I still have it and have learned to live with it. I haven't had the experience of working

> with clients who mentioned suffering from Tinnitus as a result of bereavement.
>
> (WBS, Questionnaire response 2017)

In the absence of any specific reference to tinnitus within existing bereavement literature, I turned to epidemiology studies in support of my own limited empirical evidence. These identify diagnosis of chronic tinnitus where duration is six months or longer (Weise et al., 2008) with the epidemiology of the UK adult population for prolonged tinnitus being 14% and for severe distressing tinnitus being between 1% to 3%. This concurs with the Kaldo et al (2008) study in Sweden which identified 2% of the adult population suffering severe distressing tinnitus. This study further identified:

> 'Medical treatments are usually not effective in removing or reducing tinnitus' (Kaldo et al., 2008: 348).

The UK similarly found:

> 'Pharmacological treatments did not find clear improvement in tinnitus annoyance (…) its etiology is unclear in the majority of cases' (Weise et al, 2008: 1046).

Psychological distress has not been included as a variable within these epidemiological studies and, in general, the Cochrane database of systematic reviews is concerned only with the medical treatment of the condition. A study

by Hesser and Andersson (2009) correlated anxiety sensitivity and tinnitus distress, identifying that fear of physiological sensations created anxiety arousal. They claim:

> 'Cognitive vulnerability (underlies) the pathogenesis of panic disorder (…) both anxiety and depression are prevalent among tinnitus sufferers' (2009: 295).

A common error, I believe, being repeated in the investigation of tinnitus, is the medical model of co-morbidity of anxiety and depression rather than an investigation into the causality from a psychotherapeutic perspective. This is evidenced in the latest two RCT's: Kaldo et al (2008) used the HADS with a sample of n=26 who scored 18 or more. Given that the top (severity) score is 21, excluding those with scores under 18 can only result in a co-morbid correlation. Weise et al (2008) found 6% – 24% of their participants suffered from anxiety disorder, whist 60% - 80% were diagnosed with depression using the BDI as a measurement tool. Their intent to demonstrate 'a link between tinnitus and stress' (2008: 1047) has been proven with a shift in sufferers' perceptions from a 'biomedical to psychosocial illness beliefs' (2008: 1055) with participants having somatic illness perceptions. Both studies were CBT orientated, neither accessed causal factors nor treatment focused on CBT techniques to reduce the psychosomatic symptoms and underlying psychological distress.

Of course, I do not posit that tinnitus is consistently associated with or caused by chronic and / or traumatic grief. I do, however, claim that for some sufferers their tinnitus does result from such bereavement and it is erroneous to fail in acknowledging this. Screening for unaddressed, chronic and/ or traumatic grief in the first instance would greatly benefit a percentage of bereaved people as well as the NHS departments involved in the stepped medical elimination from GP to audiology Consultant and the prevalence of unsuccessful treatment for tinnitus.

2.8 Critique of traditional models of grief

Renowned bereavement theorists are Elisabeth Kubler-Ross (1979, 2005, and 2009), Colin Murray Parkes (1972, 1986, 1996, and 2010) and William Worden (1983, 2010). Each presented a model of grief based upon their research; Kubler-Ross and Parkes identified a model of specific stages of the grief process; Worden a task model formulated on the necessary work of the bereaved. Although neither theorist intended their model to be understood and therapeutically worked with in a linear, chronological structure that is precisely how it has been used by many practitioners. Whilst the intention might not have been linear, the language used to describe both models implied a chronological sequence which many professionals duly followed in their practice with bereaved people.

Elizabeth Kübler-Ross

My concern over the years in respect of Kübler-Ross' five stage model has continued to grow, having heard several bereaved individuals express their irritation of a professional's preoccupation with one stage or another, almost insisting for example that they, the client, must be angry. I highlight this particular stage as it has been the most frequent cause of annoyance and frustration to the bereaved people I have personally met. Below I insert an excerpt from one of my participants – a mental health lecturer-practitioner – to evidence how prevalent this remains today.

> 'With Kübler-Ross, everything says about anger but that was an alien thing to me. I wasn't angry. I wasn't angry after she died and yet everybody's trying to tell me that I'm angry. It was a totally alien concept to me.'
>
> (Participant whose daughter, aged 22 died in a hospice. Excerpt from focus group.)

Whilst anger is frequently present in grief work, published material, as exampled below, on prescriptive attributes of grief need to be read with caution and discernment:

> ‘When the first stage of denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy, and resentment’ (Kübler-Ross, 2009: 40).

In similar vein, a supervisee recently presented a new client who reported a previous bad experience with a bereavement counsellor who told her: “You’re in denial and avoiding grieving and it’s rubbing off on your daughter and she’s copying you”. During a 2- day event with WBS staff as part of this research project, I was informed that a placement counsellor had reported in supervision of having told a client that she was not ‘working through her grief and that she should be sorting and clearing out her husband’s clothes’. It transpired this particular placement counsellor had done two previous bereavement trainings elsewhere, prior to the WBS training programme which clearly had not been sufficiently influential.

When professionals in the field are focused on theoretical models, dialogue between the professional and the client is dominated by the professional’s agenda. The client’s phenomenological experience is discounted and expression of their true, real feelings is suppressed. Since bereaved people are emotionally vulnerable to a great extent, it is not easy for them to express their own understanding or to contradict a professional. This becomes more difficult where there is a dependency upon a professional for medical or emotional care, or support. I further posit that many professionals resort to a theoretical model as a

defense against distressing and emotional content, adopting it as a working model for their own profession whether or not it is 'fit for purpose'. My own observations and interactions with practitioners have led me to conclude that the use of a theoretical model allows the professional to retreat from the more painful experiences and reality for the bereaved; to feel more in control at a time of unpredictable emotional reaction. A model offers familiarity; something to work with, something to focus on, something that reassures the professional they know what they are doing and something that instils a sense of competency. Unfortunately, this has led to a literal translation of the five stages as the focus of professional attention. House (2003) suggests:

> '… theory is normally used as a substitute for and a defense against, the existential "terror" of being fully in the here and now of immediate lived experience' (House, 2003: 204).

I argue there has been a major digression from Kübler-Ross' (1979) intended research to challenge the target group of doctors, nurses and other hospital staff in how to respond to and work with dying people. Indeed, despite the total absence of the word 'bereavement' in the text, this model has been universally adopted as a model for bereavement work, to the present day:

> 'Denial, anger, bargaining, depression, and acceptance. The five stages of grief, first formulated in this hugely influential work forty years ago, are now part of our common

> understanding of bereavement. The five stages were first identified by Elisabeth Kübler-Ross in her work with dying patients at the University of Chicago and were considered phases that all or most people went through when faced with the prospect of their own death. They are now often accepted as a response to major life change. [ ] ideal for all those with an interest in bereavement or the five stages of grief (2009: back cover)'.

Notably, groups of trainees I have encountered with a social work background are very familiar with this model and no other. Praise from the British Journal of Social Work on the back cover strongly recommends that all those involved in social work should read it to assist them in helping people with loss – 'the social worker's commonest task' (Kübler-Ross, 2009: back cover). Conversely, my experience of training for the Post Adoption Centre (PAC) has highlighted its lack of applicability and usefulness to those assessing prospective adopters and the professionals in this field have welcomed Worden's alternative task model:

> 'It was good to be introduced to a new model (Worden's 4 tasks) which is practical and relevant. I can relate these tasks to clients' loss when I'm assessing them for adoption.' *An*

experienced Social Worker and Adoption Team Assessor (2005)

William Worden

The above is a typical comment written on the evaluation and feedback sheets from PAC trainings I have delivered. I believe its value to the social work adoption teams stems from its intrapersonal approach to loss and grief which resonates more closely with the remit of the adoption assessors; to ascertain the suitability of a person/ couple to adopt a baby/ child. Of particular value to them, has been an emphasis within the training upon grief when it is denied or unexpressed, or 'when grief goes wrong' (Worden, 2010: 134). This is an area of specialist interest to me which I find intriguing, stimulating and motivating. Not without some ambivalence, I do draw upon Worden's task model in training, having experienced empirical evidence of its relevance within my own practice based evidence. As such, his revised model which takes account of the 'continuing bonds' concept is placed in this document as Appendix 8. Even so, I argue whether the tasks must always be accomplished and challenge the linearity implicit in the task model. Indeed, the author himself states:

> 'Others support the task of mourning idea but put their own spin on how and when these tasks should be accomplished' (2010: xiii).

Colin Murray Parkes

A review of Parkes' work tells a different story in relation to models of grief with a notable development in his thinking from his first published research with widows and widowers (Parkes, 1972) to his latest co-written fourth edition (Parkes and Prigerson, 2010). Unlike Kübler-Ross, Parkes updated and refined his first substantive theory (Punch, 2006) with a second (Parkes, 1986) and third (Parkes,1996) edition which significantly broadened his conceptualization of bereavement. The fourth edition is far more inclusive to the extent that I would say it constitutes a meta-theory (Punch, 2006) with expansion into child death, neo-natal death, stillbirth, miscarriage, childlessness, non-death major loss, murder, sibling loss, suicide death and acknowledgement of same sex relationships and grief.

There is a distinct departure from the previous, heteronormative, western Eurocentric cultural values and beliefs that marked his earlier contributions to the field. The 1972 model of grief no longer presides, giving way to the wealth of his knowledge and expertise as psychiatrist and researcher into the bereaved person's experience (Parkes, 2009). I particularly value its contribution to the field in addressing the reality of some people's resistance to recovery from bereavement. This is a much- ignored factor in therapeutic work with bereaved people and I have encountered resistance from trainee therapists when

introducing discussion on this issue. At times it has seemed a taboo subject; deemed as an inappropriate, almost cruel way to think about a person who is bereaved. Despite this however, reference by professionals and those engaged in bereavement counselling to his earlier 4 stage model of grief, persists to this day. My current practice as therapist is for North Wales Police (NWP) and, when starting in September 2016, I learnt that the Police training incorporates both the Parkes and Kübler-Ross stage models of grief and it is these to which Officers refer when encountering bereaved people in the line of duty and which are the reference point for Sergeants and Inspectors with line management and well-being responsibilities for police officers and civilian staff. A reality of course is the paucity of alternative accessible literature to inform practice, most other literary sources falling within an academic or scientific realm.

Even so, Parkes 'engagement with later theorists is clearly evident with references to Stroebe and Schut's (2001) 'dual process model'; Horowitz (1997) and the impact of trauma; Klass, Silverman and Nickman (1996) on 'continuing bonds'. It is to these later developments that I now turn.

2.9 Movement away from traditional models

The Dual Process Model (**DPM)** intentionally 'represents an attempt to integrate existing ideas rather than an altogether new model' (Stroebe and Schut, 2001: 394-5) and 'integrates elements from a number of the other perspectives' (Stroebe

and Schut, 2001: 376). Its focus lies in two distinct adaptive coping strategies for the purpose of reducing negative psychosocial and physical health outcomes of bereavement. This incorporates an essential component of 'dosage' to maintain a balance between the two which is appropriate for the individual's personal capacity and tolerance of grief emotion.

This model, therefore, is concerned with two different bereavement stressors these being; *loss-oriented* and *restoration-oriented* dimensions. In the former, the bereaved person's focus is on **confronting** the actual experience of loss which would include attachment issues in relation to the lost relationship. The latter focuses on secondary stressors postulated as loss **avoidance**. These include problems such as finance, the development of new activities and the acquisition of new skills. Both processes are acknowledged as 'sources of distress and anxiety' (2001: 395). The authors postulate that the DPM is dynamic and fluid, this being captured by a process of "oscillation": 'It is proposed that a bereaved person will alternate between loss- versus restoration-oriented coping' (2001: 395). An additional feature of this model is the authors' identification of the bereaved person's need for 'time out when grieving will be left alone' (2001: 395), providing respite from either confronting the loss or avoiding it through the restoration process. This is achieved through a 'dose' regulating factor between the bereaved person emotionally and psychologically engaging with the loss or

restoration stressors of bereavement and disengaging from either: ‘dosage of grieving’ (Stroebe and Schut, 1999).

In reference to my own practice-based evidence, I give little credibility to a somewhat simplistic concept of avoiding loss through engagement with restoration- oriented coping. I concur with the principles of self –care, daily living and personal growth associated with ‘restoration’ as crucial elements in bereavement however, query the implicit notion that it is distinct from experiencing the loss. Similarly, the concept of loss **versus** restoration seems equally simplistic and largely unrealistic: loss confrontation is viewed as expression of feelings and loss avoidance (i.e. restoration) as control of feelings. I do not hold with these two distinct coping strategies in opposition to each other. Rather, I believe there is a greater interrelated and more integrated process that takes place in bereavement which is more representative of fluctuating along a continuum than a pendulum swing to the opposite direction. Since the DPM is a cognitive formulated model and my approach is located within the humanist tradition, my position on this as a working model is somewhat predictable. However, in principle I do not dispute its fundamental premise that a bereaved person moves in and out of different aspects and experiences of grief.

Bereavement and Biography (Klass and Walter, 2001) emerged as a new model in 1996 originating from Walter’s studies in bereavement. The biographical

element has strong links with the concept of 'continuing bonds' (Klass, Silverman and Nickman, 1996) though stands alone as a model in its own right. It is concerned solely with the 'loved one's' continuing biographical story as constructed and told by the bereaved: conversations with others about the 'loved one', talking to others who also knew the 'loved one', talking at the graveside with the loved one and informing them of past or forthcoming family celebrations and events, visiting a special place (tree/ bench) to spend time and 'be with' the 'loved one'. Below is a brief excerpt of the transcript from a televised documentary (3DTV, 1993) I use in training on the loss of a baby:

> 'No-one seen them (earlier miscarriages) alive whereas Geneed was different. He was a person in himself and if I don't talk about him then nobody else can, you know. [ ] It's a way of keeping him alive, is letting other people know about him who can actually ask about him tomorrow. You know and say 'well how are you about him? How do you feel?' [ ] Although he's not there, he's there for me and he'll always be there (smiling)' *Tasmin (1993)*

Tasmin clearly has the intention to talk about her son, Geneed Mohammed, to other family members and to continue to acknowledge him as a part of her family. Even in Lethal Weapon 4 (Donner, 1998), Mel Gibson's film character 'Riggs', visits his wife's grave to apologise for not having dropped by in a while and talks

over with her his contemplation of remarriage. Interestingly, Donner replaces the opening theme song from prequels 1, 2 and 3, with a new theme song *'As Time Goes By'* from the film *'Casablanca'*. The film's scene and theme song make a link with earlier discussion of Worden's revised tasks of grieving, notably task four in Appendix 8: an enduring connection.

This biographical model clearly resonates with narrative, constructivist and storytelling approaches within psychotherapy practice and research. Such examples are given and discussed within the training programme content to promote trainee awareness of the importance of the continuing, meaningful relationship between the bereaved and their 'loved one' despite the absence of physical presence. The emotional and psychological bond remains present and the bereaved person can still hold dear to their heart the loved one's beliefs, values and wisdom, allowing these to still have influence in the bereaved person's on-going life. Usually I make a brief self-disclosure (Wosket, 1999) mentioning my grandmother, as opposed to my mother as a personal example. This in turn will generate other autobiographical examples between group members.

Extending this concept further, many bereaved people sustain a role model image of someone to whom they were very close who has died. Again an example from television operationalises this in the guise of the comedy Father Ted (Channel4, 1995-1998), whose role was played by Dermot Morgan who died last year. In interview, co-writer Graham Linehan stated that when he is contemplating

whether or not a scene is really funny, Dermot is always his point of reference and so he asks himself what Dermot would say.

Mapping Grief (Clark, 2001b) originated from a study of people bereaved by suicide to be used as a clinical, multidimensional tool for understanding the grief experience. Emphasis is placed upon actively working with grief, taking into account existing models and aims to be non-prescriptive and applicable to individual and cultural differences. The author identifies the map as a tool for assessment/ education, individual therapy, use by families and in group and support work. On examination of this model, I suggest the client would need to be in a sophisticated cognate state in order to therapeutically gain benefit from its use. In the discussion section of Clark's research article, she writes:

> 'The map is not appropriate when clients are very distressed and need to tell their story. It may also not be appropriate for trauma counselling or when denial is an important coping mechanism. Those who are not visually minded may find it difficult to use' (2001b: 545)

I have included the diagram of this grief map (Clark, 2001a) as Appendix 9 from which can be seen the three time lined sections of early, middle and late grieving periods. Close examination of the specific elements to each clearly evidences the influence of existing literature and the multiple and diverse grief reactions

experienced by the bereaved. Specific feelings of shock, guilt and isolation are located within the theoretical concepts of Parkes and Worden for example, and, according to Clark's explanation of the diagram, the 'continuing bonds' concept falls in the late grieving period.

Unlike the dual process model, the map is more directly representative of the individual, multiple experiences associated with loss and grief. Particularly helpful and client-centred features are the 'mountains' without verbal description, intended to promote the client's autonomy and self-reporting of grief reactions and responses.

Continuing Bonds (Klass, Silverman, Nickman, 1996) was a complete theoretical departure from all previously authored work. It challenged any conceptual thinking inherent in psychological and psychotherapeutic domains on what was generically thought of as working towards creating or developing a distance between the bereaved person and their deceased loved one. In this, it is theoretically oppositional to the Freudian psychoanalytic view of the need for detachment; for the bereaved person to severe their bond with their loved one (Freud, 1917).

I am struck, however, by the reality that practitioners in the field have in fact been working therapeutically for a long time with this concept of a continuing bond or

attachment prior to 1996. In my own practice, this has certainly been the case and has therefore featured within my training content. I contend it is not possible to therapeutically and effectively engage with a bereaved person, without addressing their future losses and a continuing attachment to their loved one. Anniversary dates are an especially poignant time for the bereaved, particularly the first set of anniversary dates, these being; the loved one's birthday, wedding/ partnership anniversary, Christian Christmas or Hindu Diwali or Muslim Eid or Jewish Yom Kippur celebrations, and the date of death. Future anniversary dates also poignantly include; the first day a child would have started their school education, the first year of a person's planned retirement, a pre-booked holiday, a pre-planned family wedding, and so forth. An example of this latter future loss and integration with continuing life is a son or daughter's future Wedding/ Partnership – no matter how 'distant' that may be – where the bereaved person requests special mention in the ceremony and in reception speeches of the deceased loved one (parent, sibling, child, friend, significant other).

Lyrics of songs often contain examples of a continuing attachment and meaning of relationship between the bereaved person and a loved one: Madonna frequently writes lyrics about her relationship with her mother who died when she was five years old; Eric Clapton wrote about his son's death as a way of keeping his memory alive. In the Empty Arms DVD (Yorkshire Television, 1993) one of the

midwife counsellors talks to a patient about 'future losses' and the importance of 'marking' a baby's life:

> 'What may help is actually marking this baby's life in some way. Some people like to plant something or to write something down. To actually acknowledge there was the life and that you did have a baby' Excerpt*: Ruth, (1993).*

Evidently, the concept is not new and has indeed been a feature of therapeutic work in practice for some considerable time. However, it is not until the emergence of the text which evidences research into the phenomenon of people who have found ways to maintain a bond, that the concept gained credibility and authenticity. Even so, it is not such a widely known and promoted theory.

New models

Machin and Spall (2004) presented a new model which originated from Machin's Adult Attitude to Grief scale which she designed in 2001. The benefit of this new model is its applicability to losses other than death such as relationship breakdown or chronic illness diagnoses. Whilst I believe that all theory on loss and grief is pertinent across the full range of loss experiences, it is nevertheless useful to have a model which has taken account of a more diverse bereaved population. With the exception of Clark's (2001) 'Mapping Grief' research study where participants were drawn from a bereaved by suicide Australian population,

participants have traditionally been recruited from widow/ widower populations in predominantly the UK, USA and The Netherlands.

I particularly value the emphasis Machin (2009) places on vulnerability and resilience and the use of case studies to embed bereavement and psychotherapy theory into practice. The culmination of her work published in 2009 makes a most valuable contribution to the field, my appreciation of which centres on the content of her writing, not the AAG.

Not exactly a new model, rather a re-working by Leader (2008) of Freud's (1917) original paper on 'Mourning and Melancholia' formulated on a Libido Theory. Leader reintroduces the Freudian analytic concepts of mourning and melancholia into psychotherapy and aligns these with *depression* as a consequence of loss. In his paper Freud distinguishes between mourning as 'normal' and melancholia as 'pathological' with the same characteristics being present in both. It is the presence of complicating factors which defines melancholia where the bereaved person has ambivalence and conflict in detaching from the deceased loved object. For Freud, healthy mourning meant the bereaved person eventually must 'sever its (the ego's) attachment to the object that has been abolished (to the realm of no longer existing)' (1917: 255). Freud refers to bereaved people as 'clinging to the object through the medium of a hallucinatory wishful psychosis' (1917: 244) and where this persists, melancholic ambivalence, regression and self-deprecation are

present and both mourning and melancholia need to be worked with. Parkes wrote that Freud saw 'grief as a job of work we neglect at our peril' (2003: 1) . Leader (2008) attempts to make such concepts more palatable again within contemporary psychotherapy however its ethos remains one of psychopathology rather than framing complicating factors such as ambivalence within a normal range of grief responses.

From both a personal and professional perspective, I agree that grieving is therapeutic work to be done and that it is predominantly very hard work indeed. Further, from my practice base that the majority of those accessing professional therapeutic input have issues which do derive from complicating and/ or traumatic factors. I argue, however, for and propose a non-pathologising stance in relation to matters which can complicate or prolong grief. Pathologising people because there are ambivalent feelings to work through for example, is hardly in the interests of psychological well-being and is an antithesis to the potential for personal growth from very sad, tragic experiences.

2.10 Other theoretical concepts relevant to training content

Multiple losses and cumulative grief

I introduce trainees to a concept of cumulative grief which spans across a person's lifetime and use what I have named a 'ruche' metaphor to visually describe the emotional experience of cumulative grief stemming from multiple losses in a

person's life. In my review of bereavement literature, I came across Oltjenbruns (2001) incremental grief model based upon his concept of 'incremental loss' in child development where grief is re-experienced by a further loss, where one loss triggers another in childhood.

I see cumulative grief as having the same dimension of a magnification of grief with each new loss that occurs. The metaphor describes the way in which a new loss draws up previous grief experiences to join the latest one, creating an intensely packed and concertinaed block of grief: to demonstrate, I refer to the draw strings of the heading tape on curtains being pulled to create the 'ruched' effect of the material (the grief) and continuing to pull through until it is all bunched up tightly together instead of being spaced apart. Oltjenbrun's incremental loss refers to multiple losses that are related however I advocate cumulative grief is the outcome of any and all event losses that a person experiences whether or not they are inter-related and it is this term I continue to endorse in training.

Duchenne laughter

In conducting my research, I have encountered data which has been of concern to some participants, believing their responses or behaviour would be deemed inappropriate, quite incomprehensible and unacceptable to the general public. Further to discussion with the programme leader and my AA re ethical concerns,

I chose to locate this discussion within existing literature rather than example with my participants' statements as an appropriate ethical way of addressing an important issue without compromising the professionalism of participants (Bond, 2006; 2004). There are some occasions when professionals dealing with horrific and tragic situations find themselves laughing or making jokes amongst themselves which is at odds with their professional role. Bonanno explains:

> 'Laughter serves as a means of regulating or distancing the experience of negative emotions and laughter fosters interpersonal relatedness' (2001: 507) .

In particular, stressful situations will evoke laughter as a way of coping, of regulating one's emotions to dissociate from the distress involved in the on-going scenario. This is understood as spontaneous laughter, named Duchenne laughter after the French anthropologist Duchenne de Bologne who conducted a study in 1862 into human facial expressions. From his social functioning perspective, Bonanno (2001) points out that when people's expectations are violated (by horrific scenes for example), tension and stress are high for those having to deal with the situation. Duchenne laughter has a contagious dimension to it, unlike polite laughter (non-Duchenne laughter) and as such will promote supportive group cohesion; a oneness with others to reduce tension and stress levels at a difficult time. An understanding of this concept to the professional context provides a reason for the often referred to phenomenon of 'gallows humour',

particularly amongst professionals who encounter horrific scenes through the course of their work… A correlation with Duchenne laughter and grief reactions of bereaved people has also been established (Bonanno, 2001), alongside laughter and dissociation during bereavement (Keltner & Bonanno, 1997) and linked to emotion, pain and social motives (Harris & Alvarado, 2005; Zaalberg et al., 2004) and social laughter in relation to pain and social bonding (Dunbar et al., (2011).

2.11 Training Literature

Here, I do not attempt a generic review of published text on counsellor and psychotherapy training as the vast corpus of work is too exhaustive to be manageable. Rather, I focus on aspects which are specifically pertinent to this study and the research activity, commencing with a citation which captures the essence of the training delivered:

> '[ ] the knowledge produced is based on your practice. [ ] In order to make valid claims to knowledge, you will also need to back up your claims with evidence using relevant parts of your data; this may consist of extracts from interview transcripts, selected sections from your notes of classroom observation, artifacts, photographs and examples of children's work[3]' (Koshy, 2010: 119).

[3] In this study, participants' contributions substitute for 'Children's work'.

The therapist's own history of loss and grief

As a trainer, I believe it is essential to commence with participants' own experiences and knowledge of a topic both as a way of 'cueing and tuning' participants in to the training and to create the opportunity to explore and examine their personal experiences and thinking around the topic. This needs to occur before exposure to the material with which they will be working at a deeply intimate and psychotherapeutic level.

Within this field, there is a general consensus of the need for addressing personal experiences of loss and grief as a pre-requisite for engaging in bereavement work as a therapist (Wright, 2002, Parkes and Prigerson, 2010, Worden, 2010).

Worden (1983) devised a useful 15 item Questionnaire however the practice at WBS mirrors the client assessment process with a request for a written statement to accompany the application of the individual's personal experience(s) of loss and grief. This complements the use of first person narrative (Speedy, 2008) as an authentic guide for the reader to gain a meaningful understanding of not only the personal experience but also the meaning of the loss to and the resilience, robustness and subsequent growth of the applicant. To further potentiate the recruitment process of suitable bereavement therapists, the first morning of the six- day training event is devoted to participants' individual and combined experiences of loss and grief, initiated with the use of two experiential exercises

in dyad/ triad format. The following citation endorses the rationale for this practice:

> 'Workshop organizers may be accused of introducing material that is too personal, breaks down carers' defenses and causes some distress. The response to this criticism is that clients have a way of doing just that' (Wright, 2002: 108).

Full group feedback on these exercises is designed to additionally generate shared information and learning. In effect, this is a significant stage for the *generative learning* dimension of the training programme and this study which initiates participants into the sharing of individual phenomenological meanings and intimate information offered through narrative story telling (Reason, 1998). It further endorses the rich learning to be gained from others and models the relevance of both intrapersonal and interpersonal dialogue, creating pertinent 'narrative stories' (McLeod, 2010: 200) about bereavement and individual grief processes.

Training materials and the trainee bereavement therapist

My stance as a trainer has been to introduce participants to the very raw material which emerges in the counselling room. I do not dilute content because it is too painful or traumatic in order to make it palatable, yet it is a delicate balance

between presenting the harsh reality of client's bereaved experiences and not overwhelming trainees, and impossible to gauge how each trainee may react.

Unfortunately, many trainees seek out bereavement placements in the belief that they know about loss and grief through personal experience and some because they think it is an easier client group to work with clinically; they often do not comprehend that it will involve highly complex issues and horrific trauma scenarios for many of their bereaved clients. It is crucial that therapists are well prepared and competent to deal with a wide variety of bereavements, as stated below:

> 'Again, as I have emphasized throughout this book, people should not attempt grief therapy unless they have the necessary education and training. [] There are many people who attempt psychotherapy without adequate background and training' (Worden, 2010: 263).

Despite this strong view and presenting a differential diagnosis of normal and pathological grief, he only offers a set of 18 very brief 'grief sketches' for role-playing purposes on 'various grief related issues' (Worden, 2010: 262) which I suggest is a token gesture. Moreover, the sketch vignettes fall short of the complexities that many if not most bereavement therapists encounter in their therapeutic relationships.

Whilst Worden speaks of the necessity for professional training, Wright (2002) as a trainer, expresses concern about preparing trainees which, in my own professional opinion, is more akin to training non-professional volunteers. I am critical of his slow gradual process of introducing participants to grieving via a dyad exercise to say aloud to each other words such as: Loss, Death, Coffin, Cremated and Bereft. Whilst I do not dispute the relevance of such words, their use needs to be located within a context not simply as a word exercise and my preference is to immediately link this with their own personal real-world experience(s) and subsequently locate within coherent case narrative.

Bereavement work can include asylum (seeking) clients whose narratives are related to war zones and atrocities of gang rape, amputation, child and family killings. A percentage of WBS' client population has included refugees from Sierra Leone, Ethiopia, Eritrea, Nigeria, Iran and Iraq. However, traumatic death scenarios and traumatic bereavement are, in general quite common. It is essential to consider whether a prospective therapist is likely to be overwhelmed by clients' intense grief and traumatic experience. In this regard, I find it useful to discuss with and ascertain from trainees, their personal interests and activities for pleasure and relaxation; the balance between professional and private life. Part of their inner strength to do this work will need to come from personal resources and a capacity to step out of 'the dark shadow of trauma' (Hassan, 2007: 30). The

consequences of failing to do so is well documented in reference to 'compassion fatigue' (Figley, 2002), empathic strain (Wilson and Lindy, 1999) and 'burn out' (Pines, 1993).

Defense against trauma is a natural response and more recently is referred to as psychic numbing. Of interest to trainers therefore is Wilson and Thomas' (2004) assertion that psychic numbing may equally apply to the therapist, with serious implications:

> 'Psychically numb therapists will be ineffective in staying attuned to their patients. [ ] A therapist's psychic numbing may be a "mirror reflection" of the client, it is also associated with distinct negative styles of personality in therapists' (Wilson and Thomas, 2004: 124).

It is essential for trainers to acknowledge this phenomenon and professional trainers are gatekeepers to ethical and good practice which requires discernment in the suitability of trainees to work with clients per se and with specific client groups. Trauma avoidant or psychically numb therapists will unintentionally inhibit or prevent the client's therapeutic process. Hassan asserts:

> To do the work properly, the worker must be affected by what he/she hears. [] Alternatively, defense mechanisms would emerge to block off the pain. [] In the face of the

> complexity of trauma, we must learn to be humble' (Hassan, 2007: 31).

Here, I am reminded of the ethical principles and personal qualities that govern professional therapists (BACP, 2016). I take the ethical framework very seriously in my role as trainer and also wish to clearly distinguish this from therapist anxiety as a common feature of therapeutic work.

Germaine to my own training materials is the content of raw material spoken by bereaved people in the processing of their loss and grief experience. Supporting my approach, is the consensus of opinion amongst trainers that therapists need to discover and experience the raw material of the client's voice in the training programme, to avoid being overwhelmed by it when with the client in the therapy room (Wright, 2002; Wilson and Thomas, 2004; Hassan, 2007).

However, a paradoxical dimension to the above is the issue of being magnetically drawn towards and into traumatic material. Rather than trauma avoidant, individuals become entrenched or traumatically obsessed. I liken this to the neurological 'attractor state' and note Lahad's (2008) empirical evidence that for some, the mundane things in life carry no relevance or importance; the only thing that has any real meaning is traumatic material. For example, basic tasks in life

such as paying bills, do not get done; they have no importance, no meaning and hence get forgotten.

When training, I look for a balanced lifestyle in participants and their capacity to enjoy life. Whilst their handling of the actual material contributes to this, an important aspect is how they move in and out of the material being presented; how they can move from emotional affect to cognate discussion of the material and into ordinary conversation during breaks and lunchtime. Equally important, their motivation in undertaking both the professional training (Bager-Charleson, 2010) and a bereaved population as a client group.

Klass and Walter postulate an interesting hypothesis related to counsellor training:

> 'It is possible that those trained as generic counsellors, especially according to the tenets of person-centered counselling, may be more open to accepting a client's expressed desire to talk about the dead than are those who have been trained specifically as bereavement counsellors or trained in models that emphasize detachment from the deceased' (2001: 443).

I find this an intriguing hypothesis and one which is at variance to my promotion of a trans-theoretical approach and delivery in the training of bereavement

counsellors per se, such as with CRUSE and counsellors/psychotherapists who are currently working with bereaved clients. The therapeutic element of biographical narrative may well be a dominant feature however many person-centred courses address neither the relevance of attachment, nor trauma, nor the multiplicity and chronicity of bereavement patterns.

Chapter 3 Methodology

3.1 Introduction

The qualitative or quantitative paradigm was never a debatable methodological choice for me and thus qualitative literature was the first principle with the second being an approach which would lend itself to research where the primary focus was upon training activity associated with teaching and learning. The third principle, therefore, was an approach which would allow me to address diverse educative strategies for teaching and learning promoting sustainable knowledge acquisition.

3.2 Methodological choice for education research

Bell (2005) critically evaluates and considers the merits of case study, ethnographic, grounded theory, experimental, survey and action research in Education. The ethnographic attribute of capturing social meanings in naturally occurring cultural contexts requires the need for participant observation over a lengthy period of time. As the source of data collection, the ethnographic researcher role would be more suited to the study of loss and grief within a given, specified culture or sub culture. My study focuses on the symbolic representation of wide ranging, diverse responses to a universal phenomenon. In this sense, a case study approach would be feasible with WBS being ‘the case’ and, incidentally a mixed method approach (Creswell, 2009) would then be

appropriate. Essential ingredients would be missing, however: the inter-professional dimension and the iterative process to be applied to the materials.

Grounded Theory (GT) is a much-used attractive qualitative approach, generating new theory from emerging data, achieved through non-specific aspects of data or theoretical interests, with the literature review commencing following the first research interview. Since my project contains very specific theoretical and essential clinical considerations, and is not aiming to generate new theory, GT is not appropriate. On the Grounded Theory Institute website, Glaser (2009) presented a paper as chapter one for his book 'Jargonizing: The use of the grounded theory vocabulary'. His concern lay with the adulteration of classical GT by qualitative academics:

> 'Grounded theory is the buzzword in academic circles doing QDA research. Even though jargonizing cannot be stopped, it can be explained and seen for what it is and its consequences in eroding [] GT as originated'(2009: 2).

Glaser describes GT as 'a direct, simple inductive method to generate conceptual theory from research data' (2009: 2). Specifically, my research is not an evolving theory; there is indeed a prespecified theoretical context which is antithetic to GT. Nor could my research topic lend itself to the hallmark of GT – theoretical saturation. Even so, the attributes in GT of inductive and iterative processes are relevant to my methodology. Glaser claims that 'Jargonizing has legitimated the

switching of classical GT to it becoming and to being a social construction data method' (2009: 2). His colleague wrote:

> 'Here we are, fifteen years later, riding the wave of yet another epistemological fashion in constructivism' (Holton, 2009: 5).

I argue however that inductive and iterative processes do not belong solely to the domain of GT. The cyclical nature of iteration dominates and is fundamental to action research (Reason, 2008). Similarly, I do not hold that constructivism necessarily implies that conceptual theory cannot be generated from research. A constructivist approach is concerned with experiential, emotional content to accurately represent the client's perceived and experienced truth; as such it is phenomenological in nature. Constructivist psychotherapists place the client as their own expert, encapsulated by the phrase '*connoisseurs of their experience'* (Neimeyer, 2009: 84).

I link my third research principle for educative strategies with Cohen et al (2007) who argue for an interpretive as opposed to a normative research approach in Education. Bereavement is frequently unpredictable and non-conformist. As such, I believe the imposition of stratified theory of the grief process is inhibitive to a person's grief. This is especially so in respect of growth following major loss and is particularly pertinent to post traumatic growth. To promote such a strong

and for some contentious philosophy requires a solid foundation and firm base from which to disseminate this alternative view to the more traditional and established approaches in grief work. Cohen at al promote the interpretive paradigm as anti-positivist, being 'to understand the subjective world of human experience' (2007: 21). To 'retain the integrity of the phenomena being investigated', efforts must be made to 'get inside the person' [] 'to understand from within' (2007: 21). This endorses my belief in a universal phenomenon (of bereavement) being understood from a unique perspective: No one universal theory, no one universal reality or truth in the experience of grief. Cohen et al state:

> 'The imposition of external form and structure is resisted, since this reflects the viewpoint of the observer as opposed to that of the actor directly involved' (2007: 21).

Here, my educational philosophy and strategy is commensurate with my challenge to professionals to become qualitative researchers themselves; enquiring into the world of each of their clients; to become attuned to their client's unique experiences, rather than working to a static theoretical model.

Cohen et al refer to ethical acceptability and assert that 'ethical problems in education research can often result from thoughtlessness, oversight or taking matters for granted' (2007: 62). They continue: 'it is unethical for the researcher

to be incompetent in the area of research' (2007: 62). My justification as researcher into this topic is my competence in Education since 1977 and specifically for the andragogic dimension of the project, as a trainer in the public, statutory, private, primary and secondary health, voluntary and third sectors since 1982 to the current date in Higher Education. This, in parallel with my practice in the bereavement field and own experience.

Bell (2005) promotes a narrative approach within an educational research frame. She claims: 'Narrative inquiry can involve reflective autobiographical data. [] excerpts from stories for illustration purposes of a theme developed by the researcher' (2005: 21). Bell also cites an unpublished paper as follows:

> 'A narrative approach to inquiry is most appropriate when the researcher is interested in portraying intensely personal accounts of human experience. Narratives allow voice –to the researcher, the participants and to cultural groups – and in this sense they can have the ability to develop a decidedly political and powerful edge' (Gray, 1998).

The validity of 'stories' within research inquiry is evidenced well in reference to Reason & Hawkins (1988). Although a somewhat dated publication, it remains an influential text for qualitative inquiry within action research. It is particularly pertinent to research in the psychotherapy field, having been authored by

renowned researchers whose ‘professional practice has been in the fields related to psychotherapy, as well as in academic behavioural science’ (1988: 81).

> ‘This emergent paradigm of inquiry appears to us to be multidimensional (Reason, 1986). It tends to be co-operative rather than unilateral; to be qualitative rather than quantitative; to be holistic rather than reductionist; to work in natural settings rather than in artificial laboratories. When we start to see storytelling as an aspect of inquiry we discover an important new dimension: inquiry can work either to explain or to express; to analyse or to understand. This is part of the realm of presentational knowing (Heron, 1981a) – knowing expressed in art, in poetry, in dance and here in the telling of stories’ (Reason and Hawkins, 1988: 79).

Specifically, in relation to co-operative inquiry, they assert:

> ‘People are grabbed by stories, and group members will create deeper links to the area of research if these grow out of their own expressed stories. [] by responding to story with story (replies, echoes, recreations, and reflections) (1988: 100).

They challenge traditional research methodology:

> ‘We are arguing that the expression of experience, and thus inquiry into meaning, is an important aspect of research which has been almost ignored by orthodox science’ (Reason & Hawkins, 1988: 80).

They express their dissatisfaction with orthodox approaches and describe their ‘base discipline’ (1988: 81) as psychology and psychotherapy. It is however their extended epistemology and link to experiential learning, knowing and practice which offered a methodology aptly suited to the research intent for this project, identifying action research rather than the actual paradigm of narrative research (Speedy, 2008) itself, despite the relevance of narrative stories to the data generated.

3.3 Andragogic underpinnings

An andragogic dimension focuses and locates this study within an adult learning context that places value in self-directed learning (Knowles, 1980) and promotes the concept of lifelong learning (Jarvis, 2004) across multiple disciplines (Jarvis, 1997) with emphasis upon the individual’s experience and continuing professional development.

The theoretical base and rationale for the study has been extensively addressed in the previous chapter to ground the research activity in pre-specified, existing

known theory (Punch, 2006), thus placing the actual research emphasis upon the experiential, participatory nature of this project.

Knudson (1980) argues for humanagogy as a preferred theory of learning encompassing all differences and similarities between people. I hold the view that an andragogic approach caters for the same unique attributes and are commensurate with Rogers (Rogers, 2002) stance on the relevance of interpersonal learning.

The research actively targeted ways of learning and knowing, including my role as researcher to learn how best to deliver and present relevant theory and practice-based evidence in order to enhance praxis in the field of bereavement.

This located the study as co-operative inquiry within participative research (Heron, 1996) where both researcher and trainees were actively learning by engaging as practitioner-researchers (Jarvis, 1999). To arrive at an ultimate response to the actual research question, an iterative action research process is required (Jarvis, 1999). In using this methodology, Heron (1996) asserts that researchers apply their own 'canon' to the design as appropriate for their own research purpose. My chosen 'canon' therefore has been to run cycles with different training groups rather than create an homogenous single action research group.

3.4 The research question

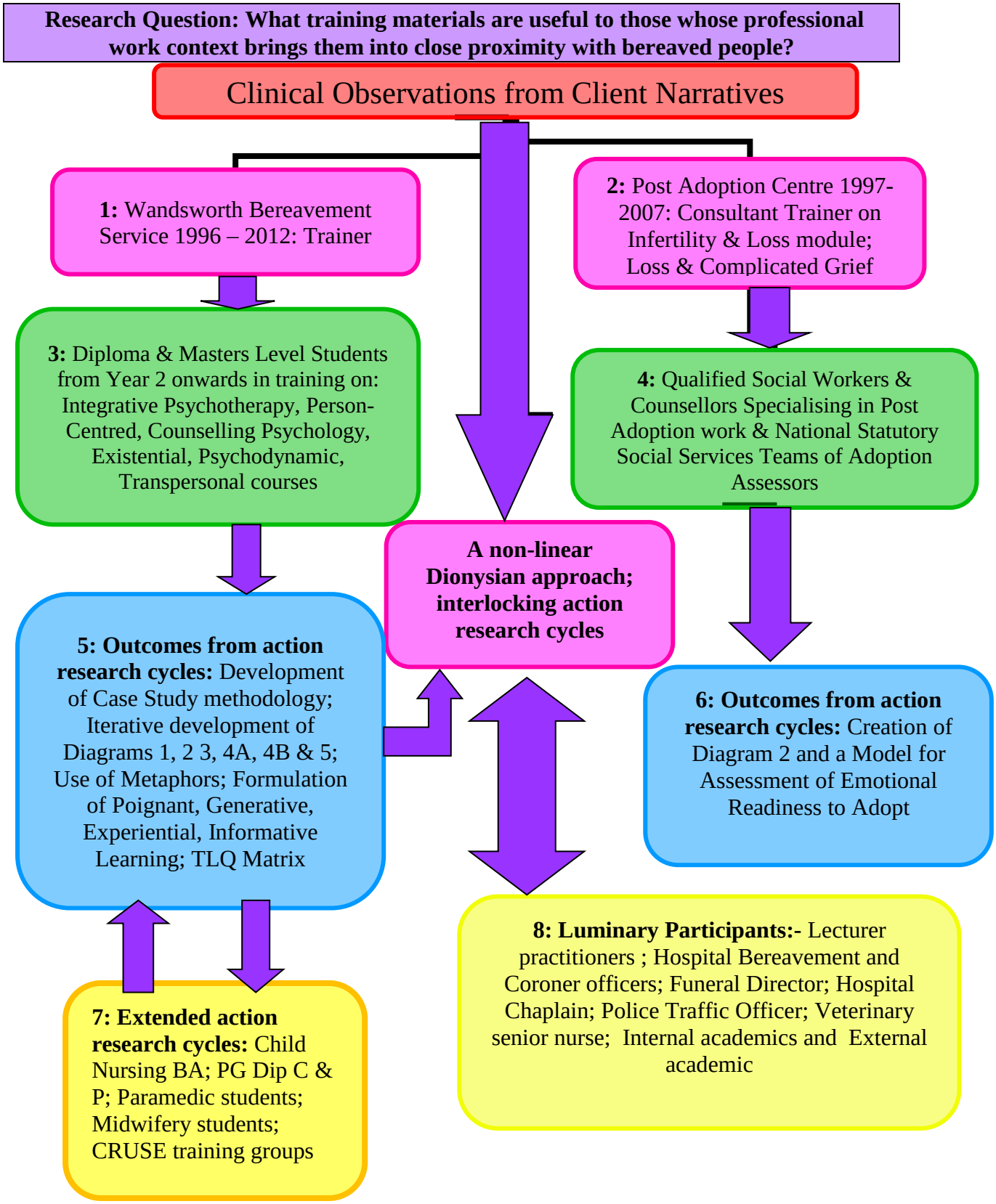


Figure 8

The preceding flowchart is a visual representation of the pathway and route adopted to answer the research question through a humanistic theoretical perspective and research lens. Silverman (2006) suggests it is the question which frames the researcher's theoretical stance. My LA in 2008 established the inquiry within action research methodology drawing upon the Dionysian approach which is central to this project, to match the non-linearity, flexibility and spontaneity of the research process (Heron and Reason, 2001).

1 and 2: identify two distinct organisations which co-operated with the research inquiry as primary sources of data. Managers from both organisations were included in my signatory list for the LA submission in 2008.

3 and 4: identify the composition of the action science 'actors' (Pedler and Burgoyne, 2008) from those two organisations who actively participated in the research cycles.

5 and 6: identify specific outcomes from the respective cycles conducted under the umbrella of each participant groupings.

7: represents additional training delivered to specific target groups which I have labelled extended cycles. These were conducted to enhance the research inquiry and involved testing out discrete topics and materials from the training programme with groups undertaking professional trainings in related fields. The HEI co-operated with my research inquiry and senior academics from the institution were included in my signatory list for the LA submission. Likewise,

Wirral CRUSE contributed with participants being a mixture of both volunteer trainees and qualified counsellors.

8: represents consultations with key professionals to further enlighten the research inquiry with their specific expertise. These I refer to as luminary 'actors', or 'luminaries' as they each provided sources of 'thick description' (Silverman, 2013) and rich qualitative data (Richards, 2009) which fed back into the action research cycles.

This research pathway highlights the high researcher involvement (Sanders & Wilkins, 2010) of my role, warranted in order to take necessary and appropriate action in respect of training content and delivery. However, this does raise the problematic issue of researcher bias and Creswell (2003) claims the researcher self and personal self cannot be separated.

3.5 Researcher bias and reflexivity

My practitioner-researcher role in this project has been one of passionate engagement, determination and immersement, pre-dating by many years this specific study purposely designed to listen to informants' experiences and views (Creswell, 2003) in order to inform future training practices. Given the already, very long term personal and professional investment, motivation and belief in this field, I was aware of the danger of imposing my own axiological biases on the research. McLeod (2003) sees the researcher as the main investigative tool and Creswell (2003) alerts the researcher to the need for critically evaluating their

own agenda. Reflexivity using a reflexive journal to add credibility (Etherington, 2004) served as a concurrent function to self- evaluation:

> 'This introspection and acknowledgement of biases, values and interests (or reflexivity) typifies qualitative research today' (Creswell, 2003: 182).

As a qualitative researcher, my own beliefs and values had to be transparently owned (McLeod, 2003) to: evidence research mindedness; monitor potential influence; reduce negative impact on the research process and skewing of its outcomes. Richards (2009) warns of the special hazards and excitement inherent in strong views and commitment to the area of research and claims that 'researchers don't have empty minds' (Richards, 2009: 23).

My allegiance to how and what I had been delivering was self- evident and quite assured; I did not have a dilemma in allegiance between 'Henman Hill and Murray Mount' (Kelman, 2009: 4). I believed in the previous success of the (my own!) training materials and definitely thought all was heading in the right direction. A very early reflexive process however, raised a methodological query in relation to the initial thoughts I had about the action research cycles.

3.6 Methodological dilemma and how resolved

Further reflection on Etherington's (2005) specialist seminar (27/5/05) greatly assisted me to unravel my struggle between staying with the original action plan to present the materials in action cycles to the scrutiny of lecturer-practitioners

or, to develop the research further with the actual training activity and trainees. This was a risk; it felt very risky as I had presented my LA and put forward a valid argument for the former. Continuing reflection focused on the andragogic nature and dimension of the research: to take account of the wealth of knowledge and experience that adult trainees would bring to the training. My own learning and research findings would best be served if derived from them as adult learners and recipients with their all-important narratives (Etherington, 27/5/05). Although lecturer-practitioner input on the materials would be of value, as individuals they would not have experienced the actual training; the essence of the experience and the free flowing meanings attached to it (Creswell, 2003).The rich, qualitative data (Patton, 2010) sought, would not be available for analysis. In reality, they would not be able to contribute to the extended epistemological methodology of the '4 ways of knowing' (Heron & Reason, 2008) in the way I envisaged. I made the decision to call upon researcher flexibility (Denzin and Lincoln, 2008), (McLeod, 1999) and took the risk to move the focus of the action research cycles to incoming groups of WBS trainees.

> 'In most qualitative research, sticking with your original research design can be a sign of inadequate data analysis rather than demonstrating a welcome consistency' (Silverman, 2010: 222).

Whilst Silverman continues to point out this will not be known ‘until you begin to analyze your data’ (2010: 222) for me, thankfully, the revelation had come when setting up the recruitment procedure. I had needed to identify who could best answer the research question (Warren, 2002) and reflected upon the premise that participants construct reality from their own experience and perceptions (Denzin and Lincoln, 2005). I sought first person experience (Moustakas, 1994) of the training which dictated that data collection take place in a ‘natural setting in the field at the site where participants experience the issue under study’ (Creswell, 2009: 175). The natural setting was WBS where participants would be trained and also undertake bereavement work with the WBS client population.

However, I did not want to lose valuable critical input from highly experienced professionals in the field. I therefore incorporated an additional action cycle (F) which I identified as having a validity function to the research. I subsequently set up an audio-taped, 1.5hour focus group with lecturer-practitioners as an extended, validation cycle in respect of the training materials. Since this was attended by only a sample of 3 people out of a potential group of 12, I then subsequently negotiated a 2-day validation event of 12 hours at WBS which was attended by three employed psychotherapy staff and two external, consultant supervisors – all experienced senior practitioners.

Additionally, I enhanced research validity with two individual audio-taped, semi-structured interviews with a male and a female practitioner as luminaries to the

research, both of whom have key attributes: senior practitioners with experience in a psychiatric, NHS mental health setting; clinical supervisors; lecturers to masters' level and practitioners in private practice.

3.7 Research Design

I conducted the study using interlocking action research cycles (Rowan, 1981) in overlapping and different time spans in three different locations:

The WBS training took (and still does) the form of a six-day training once, and occasionally, twice per year where each group participated in a six-day intensive training of 42 hours in bereavement, loss, grief therapy.

Post Adoption Centre (PAC) trainings were for one day as a component of an accredited PAC ACE module on Infertility & Loss where my input focused on the impact of loss and grief and, additionally, one day to Statutory Social Work Assessment Teams at different geographical locations in England.

To both organisations, I had been delivering training for a period of ten years prior to commencement of the action research cycles and consequently, the research activity proper was informed by pre-doctoral natural data.

The third location related to my academic role within Higher Education affording me the opportunity to extend the action research with specific programmes: BA (Hons) in Child Nursing, PG Diploma in Counselling & Psychotherapy, degree programmes for the Paramedic and Midwifery courses and request from CRUSE to deliver training. Below, a visual representation of the action research activity.

Action Research Cycles

Figure 9

'Luminaries' to this research have previously been mentioned so to clarify their role and how they fit in to the research design, the table below sets out their significance.

Luminaries to the Research

Table 4

Data collection:	Nature of participant's contribution:
1:1 audio – taped, semi-structured interview	Senior Veterinary Nurse: her experiences of clients bereaved through pet loss
1:1 audio – taped, semi-structured interview	Mental Health Practitioner, Trainer & Supervisor: her experiences of grief, mental health and well being
1:1 audio – taped, semi-structured interview	Mental Health Practitioner, Trainer & Supervisor: his experiences of grief, mental health and well being
1:1 audio – taped, semi-structured interview	Police Sergeant and Senior Investigating Officer: experiences of road policing; issues and practices around road traffic collisions
1:1 audio – taped, semi-structured interview	Hospital Bereavement Officer: nature of the role and daily tasks; its challenges and complexities, responsibilities and lines of communication/ liaison
1:1 audio – taped, semi-structured interview	Coroner's Officer: experiences and difficulties facing bereaved people from the perspective of his coronary role
1:1 audio-taped, semi-structured interview	Clinical and Operational Manager of Wandsworth Bereavement Service
1:1 brief consultation of 30 minutes	Funeral Director: exploring sensitive issues to avoid additional distress to bereaved people

The decision to include such professionals arose from knowledge I had learnt and gained from my own group of clients in pre-doctoral years about difficulties and distress they had encountered specifically after the death of someone they loved.

I drew upon action science principles to establish procedures which would better inform appropriate training content and delivery. The values of 'uncertainty, difference and conflict [are] opportunities for generating new knowledge' (Friedman and Rogers, 2008: 253) and are embedded in action science, requiring the researcher to be non-defensive when questioned and challenged. I made a conscious a priori decision that during individual and focus group interviews I would only refer or respond to factorial data and engage with new emerging information to avoid the risk of influencing from my own agenda and bias.

I therefore determined from the outset, using the Participant Information sheet to actively promote and encourage participants to give feedback on the limitations and gaps they experienced in the training, and reinforced this prior to commencement of recording. In doing so, I hoped this would also transparently convey that my research was not designed to promote my own axiological position but was intended to draw upon their perceptual field: their reality, not mine.

However, bracketing (Saldana, 2009) of my beliefs and values would not establish the more rational scientific explanation I sought, nor would total reliance upon a social phenomenological inquiry into participant experience. One participant's construction of reality (Neimeyer, 2009) would not necessarily be another's. Whilst I did not harbour thoughts of a 'one size fits all' – a positivist,

reductionist, unitary outcome - I was looking for an end product to signpost future direction in training.

Teaching tools and strategies were integral to the research methodology and key to the educational sustainability of this project. To enhance research validity, reliability and credibility, I believed these needed to be evidenced not merely implied or claimed as inherent. I therefore designed a Teaching, Learning, and Quality Matrix (TLQ: Appendix 10) to use as field research during the training activity, mapping trainees' learning relationship to the actual materials being delivered and their knowledge acquisition interpreted through the application of Heron and Reason's (2008) extended epistemology. 'Framing' participants' references to specific content, facilitated the mapping exercise within an action science concept:

> 'They (frames) lend internal rationality to our theories of action. [ ] Action science inquiry makes this experimentation process explicit and open to conscious reflection for the purpose of learning' (Friedman & Rogers, 2008: 254-5).

I integrated this framing concept with the usual training practice of full group discussion and feedback following specific activities such as case study work, experiential exercises and visual materials throughout each day to identify 'critical incidents' (Saldana, 2009) or moments in participants' learning, using

my own memos and flip chart data as field notes (Saldana, 2009). I then entered the participant- reported, critical learning topic – (the actors' frames made explicit during training) – into the relevant matrix set. This facilitated the build-up of a macro perspective of the teaching-learning activity and, importantly, allowed me to identify by its absence, what was not being reported. I hoped that by grounding the research in action science in this way, that it would engender a more rigorous and robust approach to the research.

The use of focus groups was an integral part of the design which replicated the natural context of the teaching-learning environment, participants' familiarity with the setting and their engagement in dialogical processes of experiential and critical discussion and debate. This latter, inclusive of published articles and research papers, as well as my own materials, distributed during the training.

3.8 Research protocol for the action research cycles

The procedures I adopted remained consistent with the Dionysian approach whereby research activity does not follow a linear, logical sequence but rather the whole process from recruitment to analysis and final outcomes consisted of overlapping research activity with flexible time lines. This comprised of cycles of action, reflection, action and outcome which interlocked with different groups of participants to an outcome of the co-operative participatory inquiry derived from an extended epistemology (Heron & Reason, 2008). Here, too, a reminder

that I intentionally applied my own ‘canon’ to the action cycles as a means of involving participants from diverse professional trainings and backgrounds to capture a wider group of ‘actors’. This was an important strategy in an effort to incorporate trainees from different theoretical orientations and models of therapeutic working, especially given that recruitment to the training programmes at WBS and PAC were not within my control.

3.9 Recruitment and sample

Professional motivation and investment in their respective fields and own career paths had led participants to apply for the WBS and PAC training in the first place. Heron makes a distinction between participant action research (PAR) and co-operative participant action research on the basis of whether or not the participant is ‘educated’ about the topic. In PAR, the researcher is the one with the knowledge and motivation to want to empower participants to bring about change. My participants were self-selecting and already focused on their future paths (further supporting the andragogic quality to this research) and were not ignorant about the professional field. Indeed, all participants had completed a minimum of two years professional training and all were on a professional training course, either undergraduate or, predominantly, a masters level course, or already qualified in their profession. Their applications had been processed by the respective organizational managers which included checking their professional credentials and personal suitability for the training.

3.9.1 WBS recruitment and sample

As trainees, they had been required to submit a statement in respect of personal experience of loss and grief and an organisational policy was in place, to exclude applicants who had had a bereavement within two years prior to the start of a training programme.

Recruitment from WBS to the research study was therefore an easy and simple process with no need for exclusion criteria information to prospective participants. I therefore distributed at the point of the training, my invitation and Participant Information sheet (Appendix 11) and Release Agreement/ Consent form (Appendix 12). For this latter, my preference was to adopt a 'process consent' (Creswell, 2009) protocol as the most appropriate and beneficial for participants, giving a flexible time span and to allow withdrawal at any stage up to the point of the recorded focus group taking place.

The three WBS research cycles from 2007, 2008 and 2009 included participants from diverse theoretical orientations and professional training institutes. In total, there was a training population size of n= 31, representative of Existential, Gestalt, Integrative Psychotherapy, Integrative Counselling & Psychotherapy, Person-Centred, Psychodynamic, Transpersonal and Counselling Psychology professional training modalities.

Later, at the stage of collecting post training data, I encountered difficulty in arranging focus groups at WBS. To address this, I re-issued by email my PI and Release forms, together with a Bereavement Training Qualitative Questionnaire to former trainees, via the WBS manager. In my reflection stage, I had deemed this procedure to be ethically essential as it was she who had knowledge of personal changes and circumstances in the therapists' lives; some had left WBS, some had relocated outside of London and even the UK since I had trained them. I was ignorant of their personal situation and, mindful of Bond's (2006) specialist seminar (18/1/06) on 'Prioritising People or Knowledge', did not consider it appropriate for me to chase previously willing participants who had given 'process consent'. In the event, the manager sent out 17 email sets to individuals who were still at WBS. Additionally, I sent out three email sets to former WBS therapists who had left and requested to still be included in the later data collection. Response to the Questionnaire was low, with only four returns. Fortunately, having noted the difficulty with 'process consent' earlier in the study, I had established one focus group at WBS using stratified, purpose sampling (Creswell, 2009) to capture participants' different theoretical trainings and their length of practice experience at WBS. Additionally, I held the 2009 focus group immediately following the 6- day training event.

Much later in 2015, unexpectedly and spontaneously, I received email communication from a former Metanoia, PC MSC student who had literally just

started the first three days of the six- day training. Her impetus in contacting me derived from her shocked surprise that the training materials being used had my name on them and that she did not know I had been Director at WBS. She continued with further communication after which I invited her as participant to this study. More recently still in 2017, three former WBS trainees of mine asked their supervisor (a colleague) how I was. On hearing I was finally completing this study for submission, they registered their continued interest via email. Having previously been recruited under 'process consent', I simply emailed each with a new evaluative Questionnaire for their feedback. These latest four participants, therefore contribute to the validity check, cycle F in Figure 9 (p. 115). So too, the much earlier 2-day validation event at WBS involving 5 participants.

3.9.2 PAC Recruitment and sample

Recruitment to the PAC trainings had, likewise, been the remit of the training manager consisting of professionally qualified and employed Social Work Assessment teams in the Adoption field and qualified counsellors who wished to work therapeutically with people wanting to adopt. Participants were not required to write a personal statement, nor to apply for the training as such, this being dependent upon group size for specified dates.

Participants completed evaluation forms for their contribution to the research data. In respect of the early action cycles with PAC, signatory consent was given

by PAC as the training provider for use of my field notes and the qualitative evaluations from the training days in the period 2000 to 2007. For the actual research sample, this involved training delivered to five Statutory Social Work Assessment Teams at different locations in England and five Infertility & Loss modules for the ACE counselling course, providing in total a sample size of n=90.

3.9.3 JMU recruitment and sample

For the extended action research at JMU, I followed the email procedure for recruitment using the module code email facility to students registered on the modules which were theoretically matched with the nature of my inquiry: the BA (Hons) Advanced Practice module for Child Nursing and the PG Diploma Theory of Counselling & Psychotherapy Module. Subsequently I set up separate (unrecorded) focus groups of 1.5 hours duration, each consisting of twelve participants. Later, by invitation due to my role at JMU, I delivered 3 separate trainings to Wirral CRUSE participants with diverse levels of practice experience and from whom post training data was received in the form of training manager collated evaluation.

Participation of a trainee midwifery group arose following my negotiation to deliver a day's training on the 'loss of a baby', attachment and the grief process with the programme leader. Similarly, so, a day's training negotiated on trauma and traumatic experience to students on the Paramedic programme. In this case,

participants were a mix of those undertaking a first training as a paramedic and those with years of experience required to professionally update their training to remain as paramedics rather than be re-assigned as ambulance drivers.

Recruitment for the validity cycle (F; Fig.9; 115) with the Mental Health lecturer-practitioner focus group followed the same invitation by email procedures, resulting in three participants in one, 1.5 hour recorded session.

3.9.4 Luminary recruitment and sample

For recruitment of the luminaries to the study, I adopted a personal approach of purposive sampling (Creswell, 2009), targeting individuals known to me through professional networking that I knew to be experienced in their own specialist field. In this instance, I either gave or emailed to them a Luminary Participant Information sheet (Appendix 13) and the Release Agreement/ Consent form (Appendix 12). I conducted 7 individual, semi-structured, audio-recorded interviews of approximately an hour's duration and one unrecorded, shorter consultation, using field notes. One professional I approached declined to participate. Contributing luminaries are previously presented in Table 4 (p.116).

3.9.5 The participants in the Action Research Cycles

All participants are represented in the Tables below to identify their specific contribution to this study. The number in the group is representative of the larger training populations (Sanders & Wilkins, 2010).

Table 5.1

Method of data collection	Number in group	Nature of the group composition to whom training delivered:	Year of training event or other significance	Year of data collection
Focus Group 1 **Cycle B**	6	WBS group of 12 trainees in preparation for their clinical placement	2007: 6 -day course	2008: I Year later
Field notes during the training days and evaluations received **Cycle D**	Total: 57 Total: 42	PAC trainings to SW Adoption teams x 5; ACE Adoption counselling courses x 5	2007 1- day events for both and development of diagram 2 on natural grief process	2007 for both
Focus Group 2 with field notes **Cycle E**	12	Cohort of 24 Child Nurse students at end of their Yr 2 BA (Hons) going out on 12- month Hospital placements in: Medical, Surgical, Palliative, Neo-natal, Paediatric 133ecogn.	2008: 1 -day training event on loss and attachment	2009: I year later; end of their 3rd Year BA (Hons) degree
Focus Group 3 **Cycle B**	7	WBS group of 7 trainees in preparation for their clinical placement	2009	2009: Immediately following the 6-day training
Focus Group 4 **Cycle B**	3	WBS group of 12 trainees in preparation for their clinical placement	2008	2010: 1x 2.5 yrs. & 2x1.5 yrs. Later
Focus Group 7 with field notes **Cycle E**	12	PG Diploma students on Counselling & Psychotherapy course	Therapist's Tribute & Experience of grief, diagram 1	2009
Field notes during training **Cycle E**	16	PG Diploma students on Counselling & Psychotherapy course	Topic: Continuing bonds,	2009

			attachment and diagram 4	
Focus Group 5 **Cycle F**	3	Mental Health Lecturer-Practitioners	Validity event of training materials	2010
Focus Group 6 with field notes **Cycle F**	5	WBS staff: 3x therapists; 2x external supervisors	Validity event of training content	2010
Field notes during training **Cycle E**	18	PG Diploma students on Counselling & Psychotherapy course	Topic: When grieving process is inhibited diagram 3	2010
Field notes and collated evaluations **Cycle E**		CRUSE training day	Topic: Suicide ideation and suicide bereavement	2012
Field notes and collated evaluations **Cycle E**		CRUSE training day	Topic: Trauma and traumatic experience	2012
Field notes and collated evaluations **Cycle E**		CRUSE training day	Topic: Continuing bonds and attachment	2013
Field notes during training **Cycle E**	58	Paramedic student cohorts from Year 1 and Year 2	Topic: Trauma & Traumatic experience diagram 5	2014
Field notes during training **Cycle E**	8	PG Diploma students on Counselling & Psychotherapy course	Topic: Trauma experience diagram (5)	2014
Field notes during training **Cycle E**	24	Midwifery student cohorts from Year 1 and Year 2	Topic: Loss of a baby; attachment and bonding; Diagrams 4A and 4B	2014

Individual participant data contribution by Questionnaire via email communication

Table 5.2

Method of data collection :	Participant	Year in which took WBS training:	Year of data collection:
WBS Training Questionnaire x 4 **Cycle C**	1x Counselling Psychologist PhD; 1x Integrative MSc; 1 x Anonymous MA or MSc 1 x Person-Centred MSc	2004 2007 2007 2009	2010 2010 2010 2010
WBS trainee **Cycle F**	Post, PC MSc training; undertaking WBS training delivered by current Manager	2015	2015
Questionnaire **Cycle F**	Former WBS placement therapist: MBACP Registered Psychodynamic Psychotherapist and fifth year MSc Integrative Psychotherapy student	2012	2017: 5 years later
Questionnaire **Cycle F**	Former WBS placement therapist: Integrative and Humanistic/ Integrative MA Qualified	2010	2017: 7 years later
Questionnaire **Cycle F**	Former WBS placement therapist: Counsellor and MSc Integrative Qualified	2012	2017: 5 years later

3.10.1 Data Collection Process

I collected raw data (Bazeley, 2007) by audio recording the individual interviews and some focus groups, transcribed them in full and included all data cases for analysis, thereby increasing authenticity and reliability (Silverman, 2010) of and confirmability (Silverman, 2006) to the research. I assigned pseudonyms to all participants, omitted any temporal references or demographic details

(Loewenthal, 2007) and particularly sensitive material. In a few instances, I omitted substantial portions of narrative when transcribing recorded interviews. I adopted Flick's (2009) adaptation of Drew's method of transcription and included trivial overlaps which Silverman (2006) suggests adds reliability to interpretation. More significantly however, I found overlapping dialogue, and pauses better captured the nuances and participants' meaning making and equally helpful during my reflection cycles to 'make sense' (Rowan, 1981) of the raw data. Full transcription also avoided the problem of anecdotalism in research (Silverman, 2010) where only selected data is included by the researcher, increasing researcher bias with skewed data. He promotes the principle of using 'smaller datasets [which are] open to repeated inspection' (Silverman, 2010: 278).

Audio and video recordings are viewed as 'directly observable (hard) data' (Friedman and Rogers, 2010: 255) and Creswell (2009) advises researchers not to rely upon a single data source. Whilst I had different data sources for my research inquiry, I additionally collected and transcribed data from televised documentaries of autobiographical narratives of bereavement experiences. Action science uses personal cases of social actors (Friedman and Rogers, 2008) and, as a direct outcome of the reflection cycles, I collected televised raw client data for use as the training materials continued to evolve and develop. Similarly, through later reflection cycles, I further added brief film excerpts.

Both the media-generated and interview transcripts constitute the raw data valued in qualitative research for its thick description (Geertz, 1973; Silverman, 2011) and rich text (Richards, 2009). As such, I treated all collected data as having equal validity, adopting a horizontal, non-hierarchical approach to its meaning and, having made this a priori decision, it assisted in the bracketing (epoché) of my own world view when working with the data.

The content of field notes came from data collected as memos and flip charts used during training events and also in spontaneous, ad hoc moments 'to identify and follow processes in witnessed events' (Silverman, 2010: 230). This citation further applies to documentation as evidence; the qualitative evaluations from the early, pre-doctorate PAC cycles, qualitative WBS training questionnaires and CRUSE evaluations. Where training events took place, whether one day such as the varied extended research cycles at JMU (Cycle E), or those through the PAC trainings (Cycle D), these were not audio-recorded. Whilst this contradicts previous reference to Silverman's argument re authenticity and reliability, the materials were repeatedly scrutinized through delivery to other groups of participants over time and with a discrete focus on each diagram, these being the essence of this study.

3.10.2 Data Analysis

I feel obligated in this section to acknowledge from the start, a lack of consistency in my handling of the data and although one single method is not mandatory in research, such as when using triangulation (Silverman, 2013), representation of my data moves from the use of Nvivo software to manual handling.

In respect of all data collected, whether audio-recorded focus groups or not, whether field notes and memos, documentary (questionnaires), I perceived and recorded all single, unique responses as being of value. Bryman (2004) claims the research emphasis is on words, not quantifiable data and as the adopted thematic analysis developed, I applied Process, Emotion and Values coding to capture and represent emerging deeper intrapersonal and interpersonal participant experiences, meanings and actions. From the 'emic' position and research lens (Prince, 2003), placing emphasis upon the words of informants takes account of world views and personal perspectives. These can include non-verbal clues read by the researcher and are 'constructed during coding of the data' (Saldana, 2009: 90). Punch (2006) sees analysis as communication being analysed and then meaning ascribed to the statements made by participants. These constitute essence descriptions (Punch, 2006) with which Creswell (2003) concurs as free flowing meaning which participants attach to the essence of their phenomenological experience. Denzin & Lincoln (2005), along with Neimeyer (2009) associate and place essence phenomena within the constructivist

paradigm, where participants construct reality from their own experiences and perception of events.

When analyzing therefore, I drew upon the action science concept of 'framing' to mitigate against my own researcher bias and remain open to challenges in a non-defensive and accepting manner. To realise this, I used participants' vocabulary to name the identified themes: their frames became the themes for analysis. In doing so, I hoped to bring to the research a polyvocal analysis (Saldana, 2009) which allowed for multiple and contradictory views and experiences of participants and 'frames' which did not chime with my own.

On occasion, I noted an absence of vocabulary which linked directly to theoretical concepts, yet which were properties of that concept. I therefore introduced a theme, an example being 'Compounded grief' and entered participants' own words, broadening analysis to incorporate theoretical coding. Bazeley significantly links this to the research question and states:

> 'Those working from a background of extensive reading in the literature, who have a lot of prior experience, or who are bringing a strong theoretical basis to their investigation will come to their data already with a start list of concepts they are interested in exploring, developing or testing with new data' (Bazeley, 2007: 76).

Whilst I had not drawn up an a priori list of nodes, I had come to the research with precise conceptual thinking which clearly had potential to influence analysis. Patton (2010) sees this as a quality where theoretical concepts are wedded to the research inquiry however, I was ethically aware of the need for caution and to bracket my own views to avoid skewing of the data and reducing credibility (Silverman, 2013).

I found the transcription process to be embryonic to the analytic phases, serving as early reading of each data case. Loewenthal (2007) recommends multiple readings of transcripts and during my analysis of each case, I also revisited previously analysed and coded cases, at times re-assigning them. Progressive, iterative processing allowed for deeper reflection, insight and meaning.

In the reflective phases, I used both researcher journal (Etherington, 2004) and analytic memos which Saldana describes as 'a place to "dump your brain" about the participants phenomenon or process' (2009: 32). I also discovered in the reflection cycle that such memos helped me to connect participant's experiences to existing theory.

Use of Nvivo

I initially used a QSR software package, Nvivo v8.0. via my university workplace since it facilitates coding for the iterative nature of action research cycles, adding each new incoming datum item to an Nvivo 'node' (theme) already created or the creation of new ones from new data. The data analysed through Nvivo is that yielded by participants from the Child Nurse programme.

I had previously determined not to make use of the positive and minus facility, so kept all nodes as positive ones to 'honour the participant's voice' (Saldana, 2009: 74), reduce (my) subjective bias and avoid a negative researcher inference and later interpretation during reflection. In doing so, I aimed to retain action research integrity (Friedman and Rogers, 2008). Use of the 'annotate' facility aided analysis of the coding phases. I used Nvivo for analysis of the extended research cycle with the JMU Child Nurse cohort of 12 and for the transcription of a WBS focus group of 3. Here, as well as the full transcription, I additionally imported three distinct sources: J as Jane; Al as Alex; Br as Brenda, each being a pseudonym, and An accurately representing Anne. The second coding phase analysed the three distinct transcriptions focusing on their interpersonal dialogue and contribution. For the third coding phase, I returned to the full transcription to gain deeper insight into making meaning of training experience processes and the value/non-value of training content to their actual practice of working with bereaved people.

Chapter 4: Outcomes from the Action Research Cycles

4. Introduction

The outcomes are identified below as individual components in respect of specific items and where this involves a visual representation, a brief introduction is given, followed by the item as an end product to the action research cycles, followed by data evidence for the outcome. Since Heron and Reason's (2008) extended epistemology of the four ways of knowing underpin the action research methodology, the outcomes commence with this component.

4.1 TLQ Matrix: data collected from WBS training groups

As part of the research, I wanted to capture critical moments in learning as a way of recording trainees' learning experiences: what gave professional and personal meaning to the training for the individuals participating. The emergence of critical moments were thematically identified as Experiential Learning, Poignant Learning, Generative Learning and Informative Learning, these being research generated fourfold ways of learning, creating a variant to the extended epistemology of Heron and Reason's (2008) fourfold Knowing. The TLQ Matrix illustrates the relationship between these two and records data that evoked critical moments. Process, Emotion and Values coding enabled the mapping out of data to reveal the nature of input which held significance for the trainee participant.

Extended Epistemology of 4 Ways of Knowing Mapped Against Research Generated 4 Ways of Learning

Table 6

TLQ MATRIX:	INFORMATIVE LEARNING	GENERATIVE LEARNING	POIGNANT LEARNING	EXPERIENTIAL LEARNING
PRACTICAL KNOWING: How to do something. Product = skills, competency supported by a community of practice: interpersonal, political, technical, and manual.	**Legal Registry:** Birth & Death; Hospital funerals; role of **Hospital B'ment Officer and Coroner:** inquest inquiry/ projected photos in court; travel license for body or ashes. **Police** term of **RT Collision; CPS** policy on assisted suicide	Being exposed to other theoretical orientations – including at break and lunch times – and different training practices. Other practices in: NHS services, Organisations.	A woman still has to deliver naturally a stillborn baby. Only next of kin can register a death; not a life partner. The bereaved are shown CCTV footage of events lead- ing to a suicide death.	GED1: Recognising the feeling of 'going back to square 1' when grieving; making sense of this/ gaining positive meaning; knowing client's report of experience is not a relapse in therapy.
PROPOSITIONAL KNOWING: Intellectual knowing of ideas and theories. Product = informative spoken or written word. *(Explicit, semantic knowing.)*	Metaphors: 'Ruche'; 'Ming vase'; Everest. Theoretical concepts: e.g. Idealisation / secondary gains/ **not** about 'letting go' / GED 1, 2, 3,4, 5; handouts & published papers, debate.	Other trainee's cultural roots, values, norms, experiences, including grief and burial rituals. Balinese /Hindu babies, Nigerian child, Greek, Jewish, Jamaican funerals.	Audio-visual material: authentic footage of clients' loss and grief experiences. Circumstanc es of death: 'normal' death can be traumatic - comparative trauma vignettes.	Assessment form and case studies: sudden accidental, (long term) illness, suicide, murder, traumatic b'ment, multiple / compounded loss; gay, lesbian, Hindu, Muslim, Caribbean, African, Asian.

PRESENTATIONAL KNOWING: Emerges from experiential. Product= significance revealed from expressive imagery: music, sound, drama, poetry, drawing… *(Tacit>intuitive knowing.)*	Training materials informed by bereaved people, presented using their words and narratives as information about loss, grief and bereavement. Mimetic process of presentation, not theoretical orientation; diverse case studies.	Trainees sharing in the group connections they make with the content and their own observations of grieving – people, well known to them becoming recluse/ bitter; 144ecognized; relief/ liberated; dependency; enshrining.	Expressions of grief: 'The wrong daughter died' / 'His last words: "don't be long after me" '/ 'I left his toothbrush with the paste on for 6 months'/ 'When I woke up she was dead. Her hand was on my arm'.	Dyad exercises in personal loss and grief exploration. Debriefing exercises and group discussion: examining own reactions to real client material; individual meanings and differences in grief processes – photos
EXPERIENTIAL KNOWING: Immediacy of perceiving; empathy and resonance. Present with person, place, and thing. Product= quality of being in the relationship.	Technological issues in contemporary grieving: email address/ mobile camera phone/ voicemail messages; trainees relate to distress of 'erasing' = 'killing off' experience/loss 2nd time.	Shared losses experienced by group members, including physiological responses, to grief from: death e.g. suicide, illness, broken relationship, pet loss, child/adult trauma- diverse personality response.	U-tube attachment video. Understanding of own responses to past life trauma-related experiences. Tinnitus amongst participants and others known to trainees, all who identify point of on-set, as major loss	U-tube clip; Madonna lyrics/ video; client and counsellor 'writings' in annual reports; photos –client family funeral in Ghana, Nanny of Jamaica; mask created at 'planning' for radiotherapy.

(Also produced as Appendix 15 in landscape orientation)

The iterative action cycles, resulted in a tapestry of intrapersonal and interpersonal meanings of participants' experiences being translated into the TLQ

whilst ethically preserving their anonymity and confidentiality (Bond, 2004, 2006; BACP, 2016) with regard to generously revealed personal information during the training process which was not the purpose of the study to which they had given ethical consent and a release agreement. Even so, it complied with the intention to produce emic accounts of their experiences through mimetic representation of clients' narratives. This methodology enhanced the training experience, creating more in-depth reflection and discussion on the impact of loss and grief: client provoked accounts of personal loss and grief of trainee participants; diversity of response and impact within a bereaved population; theoretical underscoring and relevance to praxis.

Essential to the understanding of the Matrix is that Heron and Reasons (2008) experiential knowing is the foundation of the extended epistemology from which emerges presentational knowing which becomes explicit in propositional knowing through a more cognate, intellectual process of knowing. The ultimate goal is practical knowing, the end product being one of having acquired the necessary skills and competency to effectively, in this case, practise as a bereavement therapist. The four ways of learning feed into the whole process from right to left, starting with experiential learning and being scooped along, gathering a wide range of products on the way towards practitioner competency.

Experiential data

Apparent during training was that their own experiences were clearly resonating with the client material being discussed. Data confirmed that participants accessed the intrapsychic (intrapersonal) meanings of their own losses and that subsequently this has informed them in practice.

> 'The self-reflective exercises helped me. They unconsciously disabled my rationalization and my detachment and enabled me to really relate to the EXPERIENCE of coming to terms with a loss. Being more open with my own feelings enabled me to be more open to the rest of the material presented as well as to the feelings of others.'

> 'I liked that there was a combination of information regarding both the physiological and the psychological processes following a loss. This information was nicely processed through practical aspects such as case studies and reflective exercises. Attention was placed not merely on the psychological processes of a client but on our own experiences of loss and all the things that we have learnt experientially through them.'

> 'The experiential nature of the training enabled me to value the importance of experiential learning which hopefully makes me a more effective teacher in various training programs.'

WBS participant 2005 ; Qual. PhD Counselling Pychology ; 2010 Questionnaire (Appendix 16)

> 'Experiential nature of training prepares well for sitting with the bereaved client.'

WBS Anonymous Questionnaire return (Appendix 17)

> I have especially valued your work on loss and sharing your work of the client dying of cancer. This had a great impact on me and I recognized unresolved loss.

WBS participant in reference to Appendix 18

Poignant data

Individual responses of trainees to particular client scenarios, material and spoken words emerged very quickly and gave rise immediately to the word 'poignant' when trainees expressed the emotional impact upon them of the client's phenomenological experience. Vignettes of poignant learning scenarios from client narratives is offered below with the impacting part of the client's story highlighted in bold:

> a) Accidental death: the bereaved client woke up **to find her partner lying dead on top of the bed covers with her hand on the client's arm. The client wanted to know the meaning of her partner's hand on her arm. Was she saying 'I'm sorry', 'I love you', or 'help me'?**
>
> b) CCTV footage: coroner's inquest into wife's death by suicide: the client was **shown CCTV footage of his wife jumping in front of a train** at the end of the platform as it drew into the tube station. Miraculously, she was OK and climbed back onto the platform and left the station. **No-one did anything, just looked at her.** He was **then shown footage of her on the platform at the next tube station before she jumped in front of an incoming train** which did kill her at her second attempt. The footage he was shown also caught her getting a taxi to the second tube station **and no-one did anything at all**.
>
> c) After partner's death: the client sitting in front of computer screen **trying to set up a new email address with just [one] name on it.**
>
> Traumatic death: 'Sometimes I dial the number just to hear his voice again. I know it seems silly and **he's not there but it is his voice so I can still hear him'.**
>
> d) A young widow who wanted renewed happiness and love in her life when she felt ready: she used ribbon to tie one end around her husband's wedding ring and put it in a special box. '**When I'm ready to stop wearing mine, I'll take it off, tie it to the ribbon and bind**

our rings together, binding us forever in memory of the love and relationship we had.'

e) Coroner's inquest into a husband's sudden and unexpected death: 'We always put toothpaste on the other's toothbrush, whichever of us went to the bathroom first. I knew he would be late home so I put his toothbrush ready and left it on the bathroom sink and went to bed. It's still there, six months on. **I can't throw it away, I've left it there: it's the last thing I ever did for him.'**

f) Coroner's inquest: A mother whose son died in police custody and whose daughter –in-law severed all communication with her; refusing contact with own grandchild and where her son's ashes were buried. **'I haven't got anything of him, no belongings, nothing. I can't even visit him. I don't know where he is.'**

g) Coroner's inquest: Husband's death by suicide at home 'I can't sleep in the bedroom **'cos he hung himself from the rafters in the roof and his body was hanging right outside the bedroom door. I opened the door and saw him hanging there.'**

h) A widow who started to have panic attacks 6 months after her husband's death. In therapy session 5, she revealed the last words he ever spoke to her: **'Don't be long after me.'**

i) A mother whose 20 year old daughter died who felt 'stuck' in her grief. One day in a therapy session, she made a cathartic revelation saying: **'the wrong daughter died'** and after which she was more empowered to process her grief.

j) An elderly client whose dog had died: 'He was my only friend. I've had him for 15 years and it's lonely without him. The house is empty and **I don't go out much but I can't get another dog. I can't go through this again**.'

Questionnaire participant:

Q4 … anything especially poignant which gave insight into a bereaved person's experience of loss and grief?

- Videos in maternity hospital
- Photographs from funerals
- Experiential aspect – others' sharing experience

WBS Anonymous respondent (Appendix 17)

Trainees' feedback of their poignant learning led me to scale down from always using full case studies in favour of vignettes, or 'scenes' as poignant scenarios for small and full group discussion, a technique later supported by a study conducted by Munday (2013). The poignant learning experiences emerged as key components and became naturally integrated into the overall training programme, being sufficient in themselves for trainees to sensitively and empathically attune to clients' emotional and psychological states. By increasing the use of such scenarios and thus creating more time, I further found that group discussion always led into more detailed content about each case from the trainees' cognitive engagement, linked to their diverse theoretical orientations, with participants embracing a more pluralistic approach (Cooper & McLeod, 2011) to grief counselling, equally reported by Munday (2013). Anonymous questionnaire respondent wrote as advice for future trainees: 'Your theoretical background will influence your work – think about pros and cons – adapt.'

Generative data

Interpersonal dialogue and storytelling during the training days considerably enriched the exchange of knowledge and particularly insight and awareness of difference and diversity; race and ethnicity, gender and sexuality, cultural norms and values and how these have the potential to give rise to complex grief. Cultural sensitivity and competency developed as participants shared their own values, belief system and personal truths, alongside viewing and discussing trainer provoked materials. Cases studies to capture the diversity of a bereaved population, use of DVD and U-tube clips, photographs and other items enhanced the learning, two brief examples of the latter being a toy owl for its relevance as an inauspicious sign in Hinduism, perceived as indicative of death if an owl looks directly at the person and, in the Islamic faith, a toy spider for its relevance as an auspicious sign from the prophet Mohammed which is looked upon favourably. As a generalization, Western, Eurocentric culture tends to view the owl and the spider the other way around. Such simple training practices led to rich discussion around diverse and differing beliefs, prejudices, superstitions, rituals and practices as exampled from WBS participants.

1. Nigerian participant: I would not be able to attend my son's funeral if he were to die as in Nigerian culture, you can't bury someone younger than you if it is your own child. This would still apply for as a UK citizen as I wouldn't dare go against this norm because of the family and community.
2. Hindu participant (1): a baby's naming ceremony takes place on the 7th day of its life and if a baby dies before then, it is not yet considered to be of this earth. Grieving, especially heavily, for the loss of a baby is

therefore not expected within Hindu culture and communities and tolerance is very low towards someone who does.

3. Muslim participant: just after my father died as I was saying my prayers, a spider crawled across my prayer mat and then I felt a lot happier and not so sad. A spider is an auspicious sign for us, coming from the prophet Mohammed. My house doesn't have spiders, I've never seen one before in the house and I smiled. I knew I was going to be alright and didn't need to be afraid.

4. Jewish participant: I wasn't allowed to go to the burial in the cemetery but had to stay in the house. I wanted to go but only the men are allowed.

5. English participant: my sister was in hospital and I didn't know she'd died. I was sent to stay with someone for two weeks on holiday. When I came back, she wasn't there and they just said she'd died. I never saw her before and didn't go to her funeral.

6. Trinidadian participant: there's a lot of prejudice in Black culture. People from Jamaica look down on people like me, from Trinidad. They feel superior and there's a power dynamic. I don't think it would work if I was allocated a Jamaican client.

7. Hindu participant (2): when people die they are cremated not buried but if a baby or very young child dies, they are buried and are thought of as 'Angels'.

8. Jamaican participant: to die from HIV is not acceptable in Jamaica and so people usually say someone has died from Cancer and the physical appearance is similar. The family would be stigmatised otherwise. It isn't OK to be gay.

9. Muslim participant (2): explained the avoidance of direct eye contact from a Muslim man to a woman as respectful and initiated discussion of the complexities and implications for counselling.

10. Several participants: A common theme emerged within discrete training groups and across the training groups, the phenomenon of idealisation amongst people they knew who had been bereaved. Frequently, this was in respect of close family members where their own experiential knowledge of the deceased person belied the picture being portrayed by

> another. Acknowledgement also took place whereby participants themselves felt they had idealised a particular individual and this generated far deeper insight into this intrapsychic characteristic of grief, and significantly so from a non-pathologising perspective.

From the above, my own generative learning from the 2007 research cycle can be identified whereby I then subsequently introduced the owl and spider artefacts into future trainings. These brief narrative 'scenes' shine a spotlight on the high importance of cultural significance and were integrated into future trainings alongside case study work, presentations and discussions to positively embrace and celebrate difference.

Likewise, generative learning and transparency around socio-political and cultural dimensions was augmented by drawing on photos from earlier field research in Nepal, India and Jamaica with participants regularly expressing their appreciation and valuing of photographic artefacts towards a deeper understanding of bereavement across different cultures.

Many Jamaican communities in the UK join in the activity of playing dominoes when a family member dies in Jamaica and they are unable to go 'back home'. As reported by many WBS clients, they would join in with this cultural norm at exactly the same time as it is taking place in Jamaica despite different time zones.

Playing Dominoes in Jamaica is a very male oriented activity. It is also a very sociable activity which bonds people together.

Figure 10

Jamaica has a 9 – Night culture and tradition when someone dies. In the 9 nights following a death, locals and people from further afield go to the home of the deceased where they talk, laugh, drink, eat and play dominoes while they reminisce about the deceased person. People bring and share food and drink and the men play dominoes well into the night. This continues up to the ninth night for the transmigration of the soul when it leaves the earthly body.

Narrating the historical story of Nanny of the Maroons provoked much discussion and facilitated a level of transparency and interpersonal communication amongst group members, opening up a dialogue about racism, white supremacy and its contemporaneous legacy.

Nanny's monument at Mooretown in the rural heart of Jamaica.

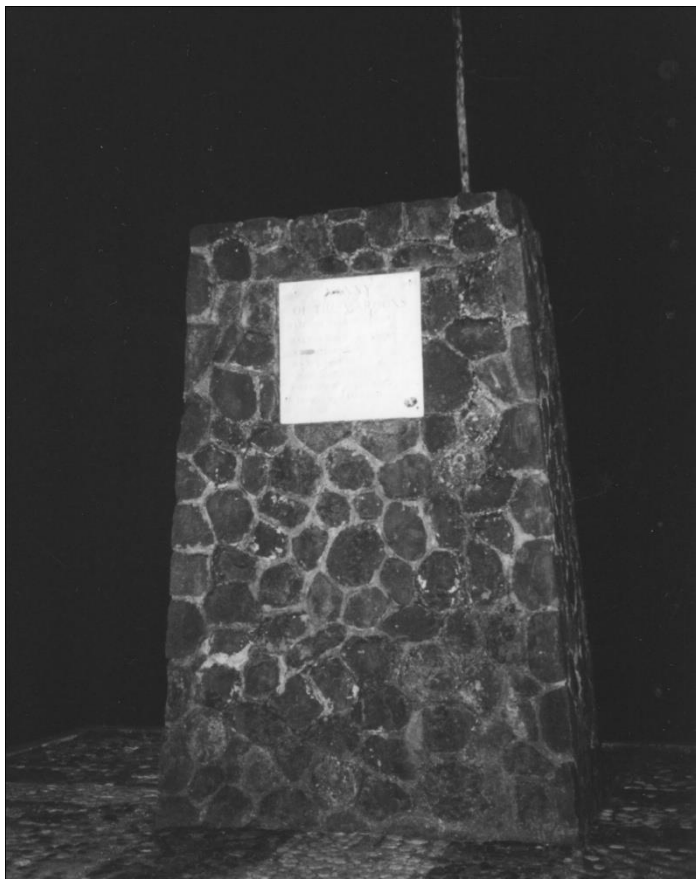


Figure 11
The plaque reads

NANNY
OF THE MAROONS
NATIONAL HERO OF JAMAICA
BENEATH THIS PLACE KNOWN
AS BUMP GRAVE
LIES THE BODY OF NANNY
INDOMITABLE AND SKILLED
CHIEFTAINESS OF THE WINDWARD
MAROONS WHO FOUNDED
THIS TOWN

Direct descendants of Nanny have retained the status accorded her by the Jamaican people. This has been handed down through the generations to the Colonel in Chief through the blood line.

The Plaque above Nanny's Grave

Figure 12

Understanding this history is central to the politics and prejudices between different Caribbean populations, African countries and British people whereby Jamaica, under command of the Maroons, was the only country which fought against the British invasion and colonialism. Jamaican nationals take great pride in this part of their history, having refused to succumb to slavery or British rule despite the atrocities committed by British soldiers upon the indigenous population. As a white middle- class trainer, I am mindful that I 'hail from [the]

‘dominant’ groups within society’ (Lago, 2007: 260) and equally mindful of my responsibility to engender open discussion around issues of power and power imbalance, oppression and anti-discriminatory practice Lago & Smith (2010). Reeves states: ‘Power (and powerlessness) are not always fully discussed in counsellor training’ (2013: 310), a statement with which I agree and yet this is a crucial component in counselling and psychotherapy training. The legacy of slavery, colonialism and racism remains ever present and is likely to impact upon any client-therapist relationship as McKenzie-Mavinga (2009) reminds us. It is incumbent upon the trainer to facilitate discourse of this nature and to avoid falling into the trap of inviting a Black trainee to tell the white trainees present of their experience. The Jamaican storytelling at WBS gave rise to deeper issues being revealed by black participants: the loss of identity and name whereby white plantation owners forced their black slave workers to take the owners surname, losing their true African name. Along with the other trainee participants, I learnt from WBS that black people with the surname of Nelson and Coleman denoted an ancestry of slavery. This too became embedded into future trainings I delivered including those beyond the research study and considerably enhanced by McKenzie-Mavinga’s work on ‘recognition trauma’ (2009).

However, for the WBS participants and despite intentionality regarding difference and diversity, data evidenced that participants did not experience the training as sufficiently equipping them to work with Black male clients as

indicated in the following extracts from the full transcription which can be found in Appendix 19.

> Al. I was just thinking in terms of I know whenever over the course of the last year, **when I've had male clients, I've sort of found it harder than you know female clients. The male clients I've had (0.2), I know we did some training on em difference and diversity. Em, but I don't know whether I perhaps would have liked a bit more em, working, you know working with men. Both the male clients I've had, have been black males** and so I think for me it's been, it has been (0.2). You know, one left very quickly and one is on-going but you know, how you think, how you actually approach that, how you work with understanding from a man's perspective what it's like to be in a room with a female therapist, or white female therapist and em understanding. I know we did, I know we did some work on diversity and what different cultures mean.
> An. Yes.
> Al. But I **think their gender, there is a gender dimension in terms of being in a chair** to, I'm not explaining this very well and (0.3)
> An. You're right. And listening to you, I'm aware that I don't particularly address the gender issue within the diversity that I do refer to or bring in to the training. I don't particularly flag up gender difference. ANNOTATE: Discussed within case work only, not as a topic in itself.

> Br And I had a client, **Black Caribbean. Exactly what you're saying (to Al). Very blocked and really very hard to start working and get to connect.**
> An. And your experience of that is, is that it's very much the cultural influence and their perception of 'self' and [ ]
> Br. From what I know about **him**, yeah that was there, that was the part of it.

> Al. Well, well, well, that's what I was just thinking about, the kind of the idea, that in particularly, the em, with the sort of **perhaps for a black male client of being a man and kind of actually blocking feelings and not expressing them and finding it very, very hard to, and coming to counselling but actually finding it very hard to override years of cultural pressure to not go there, to not cry, to not get upset, you know being aware and trying to work with that because it's, it is difficult to do that.** How do you work with somebody who you know has never really done it and is finding it incredibly difficult to do it.
> An. Mm. And when you're saying black, is that Black Caribbean or African?
> Al. Well **I've had an African and a Caribbean client where it was very much an issue in the room and almost the idea, and**

almost a paradox of thinking 'well you've come to counselling but the idea of why would it be helpful to sit in a room with you and get upset about these things and bring them up? Really, trying to get round that.
Al. There was a strong element in there, I mean it's difficult to know I'm **how much is defensiveness to protect themselves from the terrible events that have been going on around them but at the same time, it's quite, it's very, I found it and I'm finding it very hard to think, how do, how do we work around this?** How do we (0.3) What does the client want from this process because sometimes they **don't** actually want, want to get there or to think that it's (0.3)

Al. And I think that, **you know the statistics are that black males are one of the most likely groups to drop out of counselling em, and certainly my experience was that with one client it ended sort of after 2 sessions and I, and I was really dis, I kept thinking 'what did I do?** What? What? Em? Em? But I think it's, and I think you do, I think that was part of the training, I think there was something in the training to say, you know, that it is out there and that's what can happen.

Br. Em, Maybe just to have em statistically who attends the service and then just have little bit better understanding of cultural part of those people. **I've had a lot of clients, Indian clients and it has been something for me to learn about, em, it's different, it's slightly different way of approaching and understanding and so maybe it wouldn't be a bad idea to have statistically who attends and get, learn a bit (0.20**

Al. This is all in the report. There is definitely the report, the annual report. ANNOTATE Is this Al's irritation here?

J. Yeah, yeah. ANNOTATE 3rd P. J supports P Al.

Br. I remember you talking about (to An), we did talk about rituals in some countries. I remember vaguely that we did talk about that.

(WBS FG 4: P's – MSc Integrative 2.5 yrs. And MSc Psychodynamic 1.5)

Another participant specifically named 'Cultural differences in grief' as an aspect of the training that she found of particular theoretical significance in underpinning her therapy work (Questionnaire response, Appendix 17), highlighting a different individual subjective experience, whilst another stated:

Sandra: I liked the pictures, that sharing, when you put the pictures up cos you know many people don't have an image of a dead person or they have a worse picture than it is. Obviously he died without any facial disfigurement or anything else, that actual bereaved, but em, but that was interesting and **I really like the way you said how different cultures deal with it in a different way and how it's acceptable** but then how would they have dealt with it if it was a small child or you know somebody who had a loss of limb or something that would have been unable to present in that way. **And the cultures, getting into learning about the different cultures I think would be very important when working with a client. Especially with the voodoo and that suicide case.**

WBS Focus Group3; MSc Psychodynamic (Appendix 20)

Interestingly, in relation to her 'Indian clients', a participant above remembers training input 'vaguely', yet considerable attention was paid to Hindu culture in both India and Indian communities in London, including neo-natal baby death.

Indian and Hindu cultural norms for widows:

Figure 13

Above, a family group of Hindu women sit to watch the famous Goan sunset. They all live in Mumbai and are on holiday together. They span 3 generations and their different attire is culturally very significant. The woman wearing the dark coloured maroon sari is married and accompanied by her husband on this trip, as is the woman on the far left wearing a patterned Punjabi style dress. The young woman is not yet married and is seen wearing westernized modern clothing. The three older women are all wearing white garments as is the custom for Hindu widows.

When a husband dies, his wife is no longer allowed to wear bright or dark colours, only very pale pastels and preferably white according to custom. They also are no longer allowed to wear the red tikka powder along the central parting of their hair and have to break their glass wedding bangles.

This photo generated further insight into the complexities for Hindu widows as female Hindu participants described specific family situations of an acrimonious nature and of specific cultural and social expectations from within both family and the wider community. In conversation with the group of women in the photo (in 2004), they had said the prime concern for a Hindu widow whether in India or England was that she 'have money' the significant meaning of which is a home of her own and sole access to money of her own as these will be taken from her.

The natural unfolding of narratives and interpersonal dialogue has equally involved and yielded stories from white British, Irish, Western and Eastern Europeans with shared experiences being valued and all arising from generative learning. This has included discussion of cultural rituals and funeral practices, the initial stimulation for which, again derived from photographic material including those of the tributes to Princess Diana and Michael Jackson. Below, however, I present a few from Kathmandu as an example of a culture which annually dedicates a day in celebration of the dead.

Nepal: example of cultural bereavement rituals.

Gai Jatra; Sacred Cow Procession in Kathmandu (August 1990)

Every recently bereaved family must honour the soul of their dead by sending a religious procession through the streets. Here a family of the dominant Nepalese Newari clan is honouring a deceased female relative with her picture attached to the pole and her distinctive Newari ebon sari with its broad red band around the hem.

Figure 14

The parade to honour loved ones in Kathmandu is sometimes referred to as the day of the dead. It is significant as the whole indigenous population, made up of different clans or castes of both Hindu and Buddhist religions, join in the afternoon celebration which follows morning prayers at the family home. Each family procession merges to join hundreds as they process past temples, statues of idols and Gods and crowds of locals and tourists as everyone joins in with the

carnival atmosphere and local people watch from their windows as the processions wind through the narrow and hilly streets.

The Day of the Dead Parade

Figure 15

Above, a Hindu procession to honour the Nepalese man who has died, with a picture of him underneath the canopy wearing the distinctive, male Nepalese hat.

Local inhabitants sit and watch from the steep temple steps as the procession passes by. Several masks of Hindu Gods adorn his ornately decorated carriage. The family is accompanied by a troupe of local musicians and, in the background, members of this party carry banners to celebrate him in death.

A costumed male dancer making his way through the crowds.

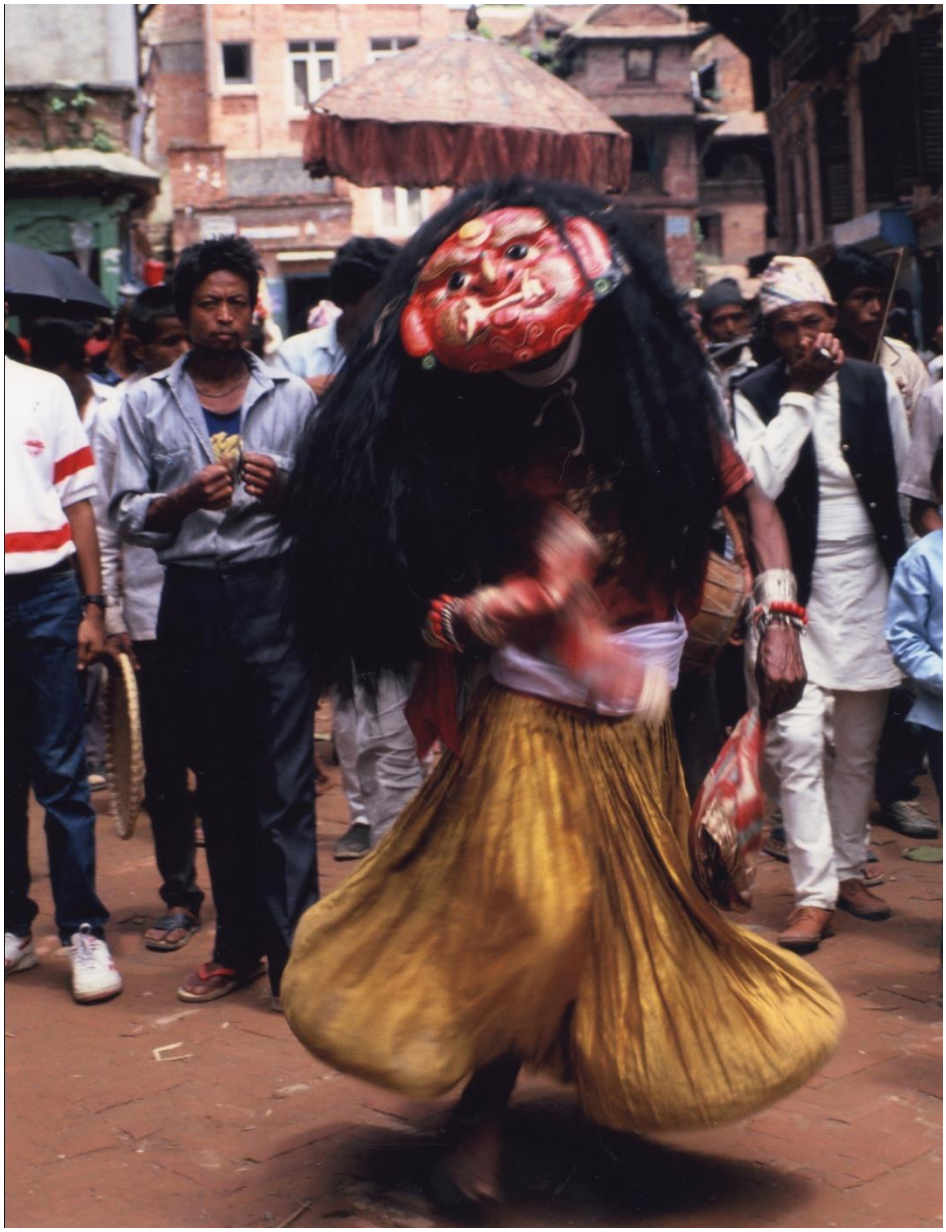


Figure 16

Musicians follow behind him with drums and pipes

Nepalese men wear masks, adorn women's' clothes and parody comedic and satirical scenes which often make fun of local government and customs.

The above is a sample of the visual stimuli used in training to generate discussion around differing cultural beliefs, norms and practices, followed by case studies to make a direct link with practice.

In similar vein, the visual below is used to initiate discussion and interpersonal communication in respect of gender and sexuality, followed as usual with specific case studies of loss and grief in gay and lesbian relationships, with equal consideration of compounded grief processes arising from disenfranchised grief due to secrecy of relationship and acrimonious family complications. The context for these latter grief processes include both lesbian and gay relationships for individuals of the orthodox Jewish, Muslim and Hindu faiths, each of which hold to a firm belief and values in heterosexual relationships as the culturally accepted norm.

> Br. Mm. And I think that was so, so beneficial. That's what you did in the training. **You gave us a lot of case studies and working through them. I thought that was brilliant. Really preparing you what to expect and working with people and having that sense.**
>
> WBS FG 4; MSc Integrative Psychotherapy (Appendix 19)

A Gay Veteran's Epitaph

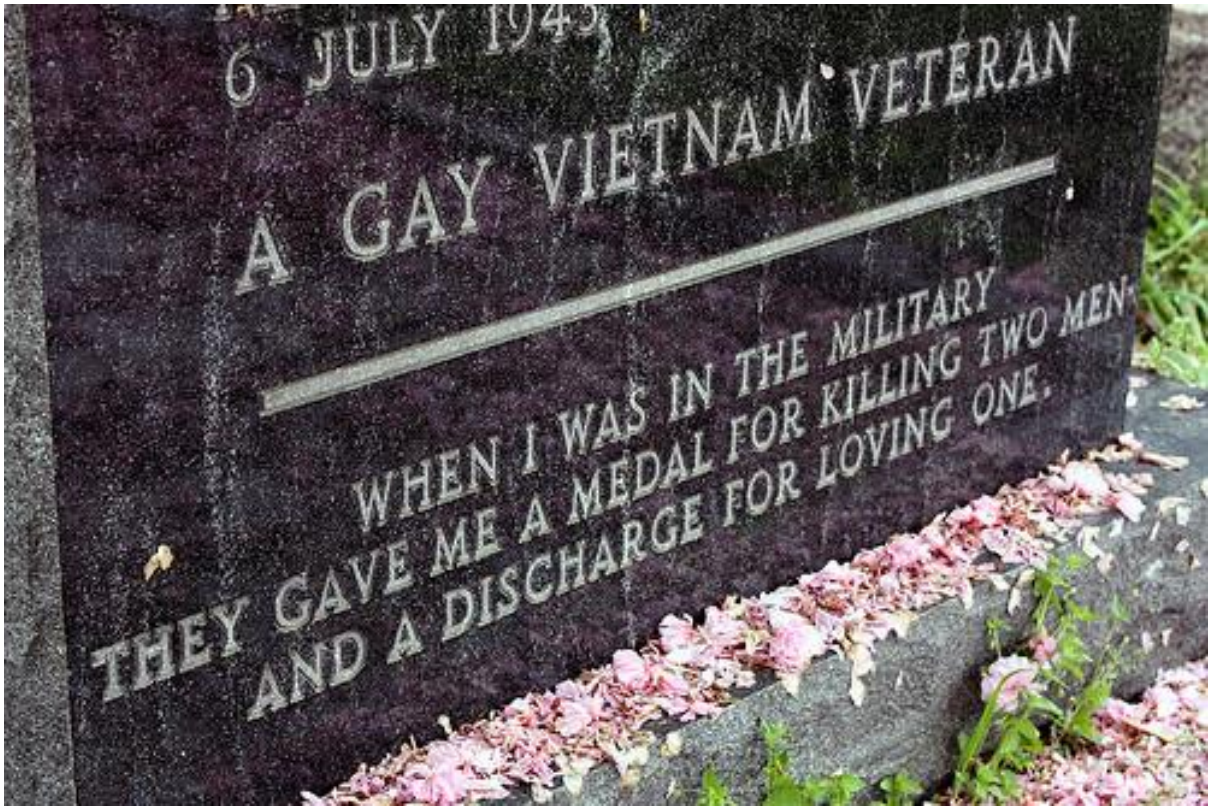


Figure 17

This provocative image lends itself well to the political landscape and debate around oppressive and anti-discriminatory practice, marginalization and prejudice. It further creates the platform for professional, ethical practice requirements of therapists and trainee therapists on placement. Participant emotions range from shock to anger and move from being emotionally 'touched' to debate issues of same sex relationships, civil partnerships and acceptance/ non-acceptance in contemporary society and personal accounts are shared in the group. Even so, notable by its absence in the data, participants made no specific reference to gender and sexuality materials although this could be implicit in their generic reference to case studies.

Informative data

Heron and Reason regard ‘practical knowing’, this the fourth of their ‘4 ways of knowing’, as the culmination of all knowledge gained, representing the individual’s skills and competency to practice their craft. In relation to this study, the practical knowing and informative learning encompasses all pertinent written information disseminated to the participant trainees: training handouts, published papers, book chapters, organizational policies, procedures and paperwork, case studies as informative material, bibliography for bereavement; all information specifically pertinent to the role of a bereavement therapist.

A key component within this, concerned dissemination about the roles of other ‘stakeholders’ of a statutory and official nature, for example that of the Registrar and the registration of births and deaths whereby, if a new born baby made a sound or breathed for a few seconds prior to dying, the parent(s) are required to register first their baby’s birth and secondly, their baby’s death at the Registry office (luminary: Coroner’s Officer). For a bereavement practitioner, it is essential to know such information in order to be attuned to the emotional and distressing experiences encountered when a bereavement occurs. Likewise, the role of the Hospital Bereavement Officer regarding all deaths occurring in a hospital context and the statutory regulations surrounding these including the legal viability to issue, or not issue, a death certificate for immediate registration

of a death, or whether the Coroner's Office needs to be involved (luminaries: HBO and CO).

To make such information digestible and meaningful, the vast majority of information was delivered through actual (real) case studies, where participants could discuss and debate the diverse issues, embedding the learning in a concrete way. Use was also made of DVD material as an initial introduction to the training topic, for example: a TV documentary, 'Empty Arms' on baby death, followed by discussion and then case study work on stillbirth, miscarriage, neo-natal and young child deaths; Joan Rivers comedy performance ending with the experience of her husband's suicide, discussion and then suicide case studies; Madonna music and lyrics video at her mother's graveside, discussion and then case studies on impact of early parental death on bereaved people; film clip 'Shutter Island' for widower experience of house fire death , discussion and then case studies involving death through house fires, road traffic collison, Such material was spread out over the six day training, much of which is represented in the TLQ Matrix on page 138.

Participant data for this section was largely phenomenologically descriptive with some specifically named training materials:

Malcolm: I really enjoyed the case studies. I enjoyed them and I found them very informative to work through and found them very helpful and priceless.

Sandra: The thing I was em, uncomfortable with was the em, couldn't get case studies to flow unless they had a name to them and using clt. instead of client and you know, so it took longer to digest the case study and then work on it.

Malcolm: The other thing I thought was very positive – I thought you were very congruent the way you led it through and built it up to explain what the client was going through.

Robert: I appreciate you've worked very hard on all these handouts. I've got a lot to read here, it's a lot of materials and it's been very interesting. Maybe for my own part I found it sometimes a little bit top down delivered.

General consensus: Felt prepared and ready to work with bereaved Clients.
(WBS FG 3; Full transcript, Appendix 20)

Br. Maybe it would be helpful to have, not, not too much but just em a little bit information about, for example adrenalin and what happens in the brain.
An. OK.
Br. A few bullet points.
Al. Mm. **'Cos I find myself wanting to know more about the neuroscience side** (*small laugh*)
An. Yeees! (*joins in with small laugh as a recognition of similar interests*)

Al. And that's not, and that's not (0.3) and **I think that's something to go away and maybe do on my own but it would be good to have a reference or something to (0.2), or this is a good book, or something to put it in context.**

Br. **Yes** (*joins in with the shared laugh and recognition of interests*)
An. I don't know. **But it may not be for everyone. So there's something in there about thinking about for whom would that be really helpful, appropriate [**
Al. Yeah
An. **And for whom might it be less so.**

J: I have to say if there's a choice between diagrams and numbers and words, **I'm a person who prefers words.**

Br. Mm. And I think that was so, so beneficial. That's what you did in the training. **You gave us a lot of case studies and working through them. I thought that was brilliant. Really preparing you what to expect and working with people and having that sense.**

Br. **You did bring Bowlby's work,** I remember that and that was tremendously useful.
An. Right. Just about that much of it! (*Gestures a small measure.)*
Br. Yes but what you brought was really relevant. It was really relevant. **Eh maybe a little more of that because he does talk about separation and loss.**

Br. **And those videos**, if I might just say a little bit about.
An. Yes, pleeeease do.
Br. This has just come into my mind. The videos were really, really useful.
An. OK.
Br. **We saw 2 or 3 and they were really useful.**
An. Can you say why?
Br. **I think one was the Tavistock (*clinic)* one.** I guess just to gain perspective, em from these bigger institutions what is it like and then, em, I remember [
J. I remember one about a baby}
Br. One about a mother losing a baby
Al. Yes, the 'Empty Arms'.
J. & Br. The 'Empty Arms'}
J. That struck me particularly as well. I found that really useful.
Al. Yeah, yes.
(0.4) Sad, silent pause
An. And I think because it's a visual thing as well isn't it? So it's, it's real. It's there in front of you.
Al. Terrible loss.
An. Yes and It's the reality of it; it's not just talking about, it's seeing it. **And did I play the Madonna video?**
Br. Yes, in our group you did.
An. 'Cos in some groups, I, I – this is the bit of the flexibility, that sometimes I might not actually do that.
Al. There was the video of the couple with the rather stern, em (0.5)
An. That's the Tavy one.
Al. Em, em, em
An. The psychoanalytic psychodynamic couple therapist.
Al. Yes.
J. Oh yes! Oh! (*facial expression of disapproval*)
An. That's always good for discussion, isn't it? That generates [
Br. Yes, it puts things in perspective. It really does. Does that style fit?

J. And I think any training would video like, **video and a bit of going away in another room and a bit of input from you. Breaking it up like that is always good cos it keeps people alert and interested.**
An. So did that, following up on that J., did that em, breaking up into the small groups and asking you to use the counselling rooms for small groups, did that work for you?
Al & J. Yes }
Al & Br Yes, definitely.

Al. **This is all in the report.** There is definitely the report, **the annual report.**

Al. (*small laugh*) I thought, **I felt we were all well trained. You know, I genuinely felt we were kind of prepared [**
Br. **Yes. Definitely. I agree.**
Al. for going into it.

(WBS FG4: Full transcript Appendix 19)

In hindsight, it would have been helpful to have **more in-depth material regarding the psychotic grief process.** Although it was briefly covered during the training, I believe I **would have been better prepared in my interventions had I been able to identify what was going on for one particular client during my training at WBS.**

With the exception of psychotic grief process, **I have not encountered a case that was not comprehensively covered in my training.**

3a) Have any of the materials remained useful to you? If so, please indicate:

I still have all my notes. I no longer refer to them all that much but **I sometimes use them to "revise", particularly when working with complicated grief.**

(WBS Validity Q.; MSc Integrative; 7 years later: Appendix 22)

I have valued my A4 **resource file** from day 1. This was thoughtfully sectioned, including practicalities with contact details; **assessment process to allocation; mandatory supervision arrangements; client attendance sheets; onward referral sources as well as client cases.**

I also **valued the evidenced-based traumatology information,**

The **lived experience of a NHS (band 4) bereavement coordinator, which supported me reflecting more upon the role of staff who interface with bereaved people.** It thus raised my awareness of the schism between the direct responsibility of such staff and their non-clinical grading compared with other staff**. I also valued reflecting upon insights of a police FLO working with bereavement and a transcript that emerged from the horror of 9/11.**

The 172ecognized case studies were very helpful and supported my reflection upon the lived experiences of past clients who had attended WBS.

Reference list- has been an invaluable resource.

My learning has helped with other clients in my work elsewhere when they have had un-processed traumatic bereavements and loss in their histories.

I've kept my A4 **file as an invaluable resource!** It was helpful to have **discussed, in my WBS training in 2012, issues about how bereavement was to be classified in DSM-5. I thread this later on in an MSc assignment.**

It has been **the most comprehensive placement training I have received to-date** to support my integrative psychotherapy training.

(WBS Validity Q.; MSc Integrative; 5 years later: Appendix 23)

1c) Please comment upon the materials presented during the training programme in relation to your clients' lived experiences of loss and grief.

It was most useful to have the mapping of the nature of **bereavement from a physiological and psychological perspective.** This particularly **helped me to see how the client's lived experience of loss and grief mirrored their developmental, cultural and environmental landscape wired into their cognitive functioning.**

The materials are a source of information that **I use as an aide memoire** when working with bereaved clients.

> We were **encouraged to ask questions** and **to challenge the current thinking on the topic.**
>
> **(**WBS Validity Q: MSc Integrative; 5 years later: Appendix 24)

As previously mentioned, enhancement of the 'practical knowing and informative learning' (TLQ, p. 138) derived from the contribution of luminaries to the research. At the end of the interview with the Hospital Bereavement Officer (transcript: Appendix 25), we jointly agreed to represent the work involved through writing a piece entitled 'A Day in the Life of a Hospital Bereavement Officer' (Appendix 26). This was and continues to be incorporated into delivery of bereavement training which trainees have found enlightening, generating much discussion in relation to inter-professional relationships involved when someone dies in hospital and the implications for bereaved individuals.

The Coroner's Officer luminary interview did not lend itself to the same idea. In respect of the latter, we discussed excerpts from INQUEST data that I had brought to authenticate findings into Coronary services in the interview and these are presented in Appendix 27. Key information follows:

> 'The HBO has instances in the hospital where the cause of death certificates the doctors write, are [not OK] and she'll get on the phone to me and say "is this right? Can he do this?" If the family go off with that certificate to the registry office, [they] will say "Oh! No! You can't register that death because the cause of death is no good!" So poor family then have to go back to the hospital, then they find out that the death's got to be referred to the Coroner. I mean, the Law states that any doctor (0.3) em, who's had (0.5) em (0.4) err (0.3) who's been looking after the patient, em, **MUST** write a cause of death certificate for that patient…Once it's referred to the

> Coroner, they look after the family and keep them informed and deal with the paperwork and won't issue a death certificate until satisfied. That's the Law as it stands today. The thing that they're up against (the bereaved) is they all vary; different officers vary in the system and handle things in different ways; some have more contact with the family than others. There's nothing set in stone – it's strange! Everybody does this job differently…' (Coroner Officer, Luminary)

Reflexively in these moments, I became mindful of the Beverley Allitt and Harold Shipman cases both of which I had studied in detail from the Crown reports and, more so, of how this data resonated with the 42 INQUEST citations (Appendix 27), these being incorporated into the training programme. A CO narrative scene:

> 'Well I had of a 40-year-old … mm … found dead in a Hotel Room hanging…
> Mm … Police went along, they were quickly satisfied that it wasn't suspicious, so the Police not involved, don't want to know anymore…
> So, they refer to the Coroner. So, I've got this man. Yes, he's got next of kin. And it's not my job to find out why he did it! So, although by Law I don't have to do it … you do it, anyway, don't you … because you're trying to help the family to, to, find out what's happened. So, I get hold of his mobile phone. I can, I can, get the Police to interrogate the mobile phone … I found that he'd been ringing these various people, numbers, one of the numbers quite frequently, so I just rang this number. She was a high class prostitute and she'd been with him before, but it wasn't just that; he'd told her that on his visits he told her that he had recently lost his father; and he'd also been to a 'family do' and at the 'family do' was a family member who'd abused him as a child and he'd had to see this family member and be polite to him. And, oh, it all unraveled… You speak to the family at some stage before the Inquest, so they, they know exactly what is going to come up in the Inquest… They know everything that there is to know before the Inquest'

Evident from the CO generated data, is its informative quality for those working with a bereaved population. Equally so, data generated from the luminary Police Officer regarding how the role of a Police FLO (Family Liaison Officer) feeds into Crown Prosecution Services. The FLO has the task of informing relatives of a death or serious injury to individuals; 'they're not to tip toe around the truth… they've (FLO) got to say the words "Your family member is dead"' or "very seriously injured" or "been killed". They can't use euphemisms like em, 'someone's passed away' or 'he's not with us now'. There is a story in (names the geographical location) of an officer who did go and say, 'I'm sorry they're no longer with us' and they took the family to the hospital, to the mortuary to do the ID and it just, it, the penny hadn't dropped.' Revealed further, the monitoring of the emotional impact upon a FLO with the use of a 'traffic light' metaphor of green, orange and red, with the latter alerting a need for a break from this role. This interview revealed an ineffectiveness in the critical incident debriefing received following tragic incidents, the participant experiencing it as anecdotal rather than addressing the specific incidents she had attended. Interestingly, she (and apparently general so in the police) referred to various incidents as involving 'grief' yet was describing instances of a traumatizing nature for her. I wondered whether this was the Force's way of ignoring the possibility of vicarious trauma for its Officers. Scenes she described highlighted situations where Officers frequently have inter-professional relationships with hospital staff, the Coroner, Fire service as well as mental health professionals in the course of their work,

reinforcing the value in a deeper understanding that bereaved people, at a time of emotional vulnerability, often must engage with several professionals, each of whom have their own professional agenda in the interpersonal communication. Replacement of the word 'accident' with 'collision' (RTC) offered significant information to be included in bereavement training, explicating that:

> 'The reason was that by calling it an accident it trivialized the meaning of what had gone on. [] a road traffic accident and your husband's died but it's just an accident. And that's not really the case cos what we say is that every collision where someone's dead, is to be treated as a homicide scene until the contrary is proved. [] So, we moved away from the term accident because of that so if you say to a family your loved one died in a collision, it still leaves the chance or the prospect that someone is culpable and will pay one way or another.'

Of equal value, information regarding sudden and unexpected deaths and, here again, the relevance of inter-professional liaison between the roles of hospital staff and the HBO, the Coroner and the Police. In this interview, the showing of photos in court 'on a big white board' was confirmed with bereaved relatives having the option to go and sit in a separate room if they preferred. Contained within the transcript (Appendix 28) are vignette narratives which are incorporated into delivery of the training.

4.2 Mimetic Traumatisation (MT): a discreet outcome

MT as a concept evolved through the qualitative nature of this action research project and has been the most challenging aspect of this study to myself as practitioner-trainer-researcher. With heightened emotions around moral and ethical responsibilities when conducting research (Bond, 2004, 2005; McLeod, 2013) and the importance of 'maintaining the well-being of participants' (McLeod, 2013: 80), I also experienced a considerable degree of shame and upset.

'Mimesis', derived from the Greek language and originally aligned to the imitation of real life through art and literature, has become associated with social science and is embedded within natural and qualitative research (Flick, 2009). Though not arising as research driven activity, my intentional use of mimesis, or mimetic material, had emerged over time as a strategy to enhance trainees' learning and understanding of the lived experiences of clients. This has long been a hallmark of my training activity, underscored therefore with detailed reference to genuine, raw material which accurately imitates or mimics the many real-world experiences which clients share and articulate in therapy sessions which Flick sees as 'processes of constructing reality' (2009: 83).

Borrowing from Riessman's view that 'Investigators don't have access to the "real thing" '(2008: 22), my view as a trainer is that trainees don't have access to real clients and their phenomenological narratives. In the pursuit to achieve this, I draw upon DVD recordings of documentaries, clips from U-Tube, films, comedy and music DVDs, vignettes and full case studies, all of which are

immediately discussed (after viewing/ reading) in respect of their pertinence to grief therapy and the therapeutic relationship. – Here, the intention is to engage trainees in interpersonal discussion around the client experience, clinical aspects of the case and relational working with the client. Though in relation to supervision, Lahad (2000) considers stories and films to engender therapeutic competency through the construction and meaning making of narratives.

Despite having good awareness of the impact of traumatic material, I nevertheless was astonished by the revelations of one research participant in WBS FG 4:

> J. I do particularly remember the commenting on the time, of **the time of day that you had trained us about it. I remember it vividly. It was a Friday night and it was dark, and it was pouring with rain and do you remember? (*looking at Al)* And we were all [**
> Br. (*Pulls head back in surprise*.) ANNOTATE: Br surprised at ref to Friday night
> Al. (*Small laugh)* All I can remember is the accident outside my house.
> J. Yeah**. I went home, and I was, I couldn't cross the road in my normal, maverick diagonal manner but had to hover on the crossing terrified [**
> An. Gosh!
> J. **of what was going to happen to me.** (Br and Al look surprised and a bit shocked.)
> An. Oh wow! ANNOTATE: Me horrified, shocked.
> J. And I remember commenting to you that although this was useful and valuable input, I think it would **have been better to put it in at an earlier time in the day's training when we could have been debriefed as it were and calmed down before we were thrust out into the night**. ANNOTATE: always done in morning session.
> Br. (*Frowns and grimaces.)*
> J. Because we were all really freaked out, weren't we? (*To Al)* Do you remember?
> Al. I, well, **I remember it very well cos I went home and then a woman had been hit by a lorry in my street** and I went home and there were lights flashing and sirens and this woman was trapped under a brick wall by the lorry just near my house. **But it did bring it all home to me and made it very real in a way that I think is important, that this isn't just something you do to get through your course. That this is hard, difficult and sometimes very traumatic work** and

> if you're not prepared, you know, if you think that's going to be too difficult, you need to know it then rather than, you know, later.

(WBS FG4: Person-centred trainee, Yr. 2 Dip Couns. Appendix 19)

Reflexively, in the moment, I was extremely shocked and horrified, and felt confused whilst equally noting the surprised reactions of the other two participants. Quickly, I became aware of also feeling irritated and annoyed with Jane as her experiencing of events was factually inaccurate – the case had been presented in the morning (usual practice) followed by debrief and discussion. Further, this was a year and a half ago so why hadn't she said anything? Carver (2017) reminds us: 'Reflexivity is concerned with asking "Who am I in the relationship?" and "Why did I respond as I did?" '(2017: 39) Shortly after, I responded immediately to Alex's experience as she arrived home, rather than staying with Jane as I was still assimilating Jane's words and later, I went to a very defensive place:

> An. But I hear your comments as well (looking at J.). With groups that I have trained since**, I have put in more psychic protection exercises and I've actually em shifted around some of the trauma work as well [**
> J. Ughuh. And have they commented on how they found it?
> An. Yes, yes. And I think it's worked out. And**, I've taken more of a vignette approach as well for the trauma element** and am focusing on the poignant stuff. I do introduce the case studies and I do use them, **but I have re-organised them in how I deliver them.**
> J. Yeah, I think that's good.
> An. **And I also took it to my own supervision.** Em it was something I took which will be a part of my, in my write up as part of my research as well. What came out for me as I really tried to stand back and reflect upon that, is that because I am so familiar with this material – I mean I know it like the back of my hand – and I don't know if it was your group or your group (hand gestures), but in one of the groups, (in an end of day debrief) **someone suddenly kind of interrupted me and said something like 'Anne, I'm amazed: you've been training all day and**

you've not looked at any notes once.' And it's true because I don't need to because I know the material so well.
Br. & Al Mm.
An. **But the issue for me was that I, I was reflecting upon it (the participant's comment) and thought I am so familiar with this, I am almost de-sensitised to it in a way [**
Br, J, Al Mm, Mm (*simultaneously)*
An. **And what I wasn't doing was standing back and thinking I'm introducing it to other people who, for whom, maybe it's the first time. So, the feedback from you is that the material is essential which is what you were saying Al, but I need(ed) to reflect more on the delivery of it.**
J. Good.

(WBS FG 4: Researcher response following Jane's revelation)

I believe that I felt my professional integrity was in question, hence my earlier annoyance, then explanations and justifications. Mindful that it is the researcher who is under scrutiny, not the participant, I continued to reflect and to experience these oscillating emotions, going back to the transcript and found this continually hard and challenging. I wrestled with the detail, acknowledging that it had indeed been raining at 5pm when everyone left on the Friday (Alex's story of her return home reminded me) and then questioned again, why Jane had said nothing on the Saturday morning – each day began with a further debrief on the impact of the previous day's material. Eventually I came to the realisation that the material had been so real and shocking that she had in fact been traumatized by the mimetically presented scene and to the extent of impairing her own functioning. Analysing her data further, I felt that she had experienced cognitive impairment and that spacio-temporal awareness of the event had remained absent: the mental representation of the event had remained in implicit memory, in the

amygdala, with no cognitive processing having taken place and thus no coherent narrative or time frame.

A further realization evoked yet more shame: Jane may not have felt it appropriate to speak out on the Saturday morning since Alex had had a 'live' traumatic experience as she arrived home and had articulated how this had evidenced for her, the need for trauma material in the training. As a trainer, the well-being of all participants is my responsibility, whether trainees and/ or research participants and knowing that someone had been traumatised through the delivery of my training and that this had not been processed in 18 months, I found distressing and difficult to assimilate and accept. I spoke with Jane after the session and subsequently, later explicated the situation to the Operational Manager for her to follow up however, this did not mitigate against my own feeling of shame.

This critical incident served as a wake-up call and the catalyst for much deeper reflection. I recalled a previous incident when running a workshop with supervisors at a trauma conference, as usual presenting genuine, phenomenological client experiences, on this occasion presenting two vignettes to be discussed in comparison from the perspective of the supervisee-supervisor relationship. About 3 minutes into the vignette reading time, a group member shouted vociferously at me for having been exposed to trauma material. Here, as I had given the usual verbal brief in the main auditorium about the workshop, including the use of raw material, to all delegates, I had made an assumption the

content would be alright. For ethical reasons, this considerably changed the running of the workshop, intention and aims for which were not achieved.

Yet deeper reflection reminded me of a former client bereaved through the 9/11 New York terrorist attack whom, I now believe, had a MT experience on two separate occasions. First during a memorial service in London when, as a surprise to those attending, the whole squadron from one of the New York 'Ladders' marched down the central aisle in full fire-fighters uniform. My client experienced panic attack symptoms and wanted to run out. She could hardly breathe and did not experience it as a respectful gesture. The second occasion for her occurred in her work place, in a high- rise tower during a fire alarm practice. Although my client had staff responsibilities, she became panicked and froze, unable to either direct her staff to, or access the stairs herself. She had never been to New York and her experiences were not connected with a re-triggering of events where she herself had previously been involved or witness to; they were created through replication of a particular scene associated with a traumatic event; through mimesis. She had of course seen much media coverage of the New York firefighters, the 'Ladders' involved, as well as the many scenes of people in the Twin Towers, thereby assimilating mental representation, picture images, of these scenes. (Client consent given in 2002 for my future use of her 'story'; her contribution to WBS Annual Report 2002 is in Appendix 1 as supporting evidence.)

A distinction between being involved or witness to and being presented out of context with text or a scene that accurately imitates the original, enables an essential distinction to be made between vicarious trauma and mimetic trauma. Recognition of MT as a phenomenon, has significantly influenced my practice as a trainer and, I suggest, that had I understood Jane's traumatic experience to be vicarious in nature, the concept of MT would be redundant and valueless, and I would not have recognized and taken responsibility for having caused her visceral response. My understanding and ownership that I had purposely chosen and presented specific material (text) to her, endorsed the fact that mimetic material had invoked a traumatic response and one which had remained unprocessed.

This new knowledge and awareness presented a dilemma, however, and I returned to the data:

> Al. It was a real; I can remember doing **particularly the trauma cases and I thought, do you know, actually yeah, I could be sitting in a room with somebody who has watched somebody burn to death in a car. Can I do that? And I think it is really important at that stage in the training to, you know, that you're shocking people in a way [**
> An. I know (*said softly, acknowledging the awfulness of the traumatic material*)
> Al. and asking them to consider, **can you, can you do it, do you think you can sit in a room with somebody who is going to bring something as horrific as the things we looked at. Because I, you know at that stage, I don't think everybody can. I remember asking myself can I? Do I think I'm up to this?**
> An. So you feel it is appropriate for me to introduce that kind of material in the training?
> Br. Yes.
> Al. **I think it's more than appropriate. I think it's essential.** Because you don't, if you don't have that at that stage of the training and it happens to you further, you know you don't realise

that it's, you know if you sort of read the annual report or something and you assumed that **actually the most likely client is somebody who's a parent who's had cancer, you may well think 'oh I can do that' but actually (0.2). Actually, I have more recently had some really sort of horrific, particularly suicides and I think I knew at some point the client with the horrific death was coming and it's not a surprise to me.**
Al. I still can't get **the burning car. Sometimes I still have mental flashes of it. It was quite (0.3) [**
An. The witnessing one? Witnessing traumatic death?
Al. Yeah.
J. For me it was the person whose inner organs were splattered all over the wall. I remember waking up on Saturday morning and cos I think in words, I was still thinking in the words of that **and I can still vividly remember that.**
An. Is this the disembowelment case on the underground?
J. Yeah. (0.7) No. The one whose partner (0.3) they, their organs were splattered…
Al. It was **a cancer death** I think.
An. Oh yes. In the bedroom?
An. Mm. And you see, there are a couple of cases where that, where similar types of scenario and those deaths are regarded as an ordinary death. (*ANNOTATE i.e. not traumatic, but a domiciliary death)*
Al. Mm
An. **They're not regarded as a trauma or they're not identified as such.** Those deaths are within the realm of normal, everyday life kind of events, as opposed to disasters or horrors of disaster stories that we hear about**. But the point about it is that the impact for the bereaved person is that it, well, how more traumatic can it be?** So that's why those are there.
J. It's funny noticing that **a particular story and there were several, you know one really struck others, another others.**
An. Mm It is interesting isn't it? (*Annotate here – individual differences / personalities*.)
J. Yeah.
Br**. I don't have a recollection of any of thos**e. I just remember thinking how useful it was just to have a case study and really **get some kind of taste of 'what am I going to embark myself into'.**
(WBS FG4 2010; Appendix 19)
An: OK. And thinking of the trauma, I'm particularly keen to have your feedback around the nature or the impact of the material upon you. Whether you felt it was too heavy, too raw, or inappropriate. You know, your reaction.
Lewis: I personally didn't actually. Cos em, **I felt it has to be raw and powerful to actually get it. If you are going to be working with trauma, you want a little bit of experience of what you're going to be working with.** I don't know if they were worst case scenarios, you know I'm sure there's worse but you know it was designed a bit to make you sort of step back but **we**

had the gap in between and I was expecting it to be a little bit worse even from the advance warning you gave us and it wasn't.
Robert: Em, Well I don't know perhaps if you sort of **em , if you'd gone about the trauma saying to ask us what do you think would be the main features of trauma or we'd gone into a group and just come up with some ideas.**
An: Brainstorming?
Robert: Brainstorming. That's just a thought actually.
(WBS FG3 2009; Appendix 20)

During my reflection and analysis phases of the data from FG3 as presented above, I conducted an interview with the Operational Manager of WBS as a luminary to the scrutiny of and insight into the effectiveness of the bereavement training. (Ref) Data revealed, contributed to my thinking and processing around the use and delivery of mimetic materials, as well as the concept of MT. (Ref)

Anne: And I, I'm really, em, aware of **what's going on for me at the moment as we're talking, as well is, because this about the admin, that is very much cognitive stuff and I'm thinking about the stuff I deliver as case study material,** some of which as you well know, is traumatic and I'm thinking here what **you've said about info and procedural stud and how the admin stuff just doesn't get processed, doesn't go in.**
Claire: Kind of 185ecognized185i.
Anne: It's well, hopefully, they're not actually 185ecognized185 but it's where the focus and emotion is.
Claire: In the trauma work?
Anne: **In the trauma work but even if it's not trauma work, it'll be connected with the feeling, the visceral experiences of a bereavement. Even if it's not a traumatic death or a traumatic bereavement. What's in the case study, even the facts about it, are something of a visceral nature because of the circumstances as it's described, of the death and the meaning of loss to that person. So, this is making more sense.**
Claire: There's something about trauma that they are **kind of over-sensated [**
Anne: **a lot of emotive material**
Claire: yeah and **there's some trauma response as there would be in real trauma, to the case studies but they need it because that's [**
Anne: **the work**
Claire: the work. If they didn't have it, then we'd have, it would be much harder.
Anne: Well, you wouldn't be able to allocate, would you?
Claire: No and they **just wouldn't be able to manage because they've got to be exposed in the training to what the real work is gonna be and whilst it may be a shock in the training, if they don't have the shock of the training and haven't been through that experience, then being face to face with a client, it's going to go all horribly**

wrong because they haven't been exposed to it. If the first experience they have is in a room with a client, they'll be even more anxious and traumatized .

Anne: Yeah.

Claire: So they do need it.

Anne: Yes, but it's interesting that, that, it, **that all that energy is there, is in the right brain the feeling, sensation side and the cognitive stuff, isn't being processed in the same way. It's not going in, not being processed.**

Claire: OK. Yes. I don't know enough about the neurological bit.

Anne: It's just that, em, where all their energy and focus is in the material which is, yeah, em, so **when they're saying I didn't get that or, no I didn't get that handout,** you know because they probably haven't gone back and read through the pack afterwards, **their actual experience is they didn't get it as they don't remember that 'cos what they remember is this other stuff around the cases.**

Claire: Yes, it is like a bereavement. They don't remember stuff. Their concentration goes.

Anne: Yes.

Claire: I mean, they are concentrating on the piece

Anne: Of course, 'cos they work very hard.

Claire: That's what's happening. And **it is like having a response to a trauma like the client is.**

Anne: Mm. Yeah. Makes a lot of sense. And, of course, for **quite a few of the trainees, it will be the first time they've been exposed to such awful material.**

(WBS Luminary, 2010)

A dichotomy had clearly emerged from within the data: complete agreement that the materials involving traumatic death events definitely needed to be included in the training and were appreciated to convey the reality of the work at WBS and equally, that exposure to traumatic material had the capacity to traumatise trainees to a lesser or greater extent. The learning for me here, as obvious as it subsequently is, is that my cautious and thoughtful ways of delivering were insufficient and that I needed to engage trainees in a way which helped them to stay grounded and located in themselves. Gebauer & Wulf (1995: 2-3) claim that '[Mimesis] produces an otherwise unattainable proximity [] and is thus a necessary condition of understanding' (cited in Flick, 2009: 78). This captures the essence of my intention however, clearly 'the proximity' was too close, too prolonged and too intense.

I had previously taken on board data from the 2009 FG3, resulting in some changes of delivery following the reflection cycle, as referred to in my defensive response during FG4.

> **An:** When you say, more bottom up, can you give me an example of that?
> **Robert:** Em, Well I don't know perhaps if you sort of em, **if you'd gone about the trauma saying to ask us what do you think would be the main features of trauma or we'd gone into a group and just come up with some ideas.**
> **An:** Brainstorming?
> **Sandra:** I don't know quite what you're saying but I've got a sort of a bit of a spin on it which has prompted me to think about what I was going to say last time. Was that **your em, when you were dealing with your em diagrams, I felt there was a space there where we could have actually worked with a real person and em built that in. So there's the picture, let's look at this person and you know build that into it sort of so it would make more sense to people who haven't actually experienced a client at all.**
> **An: OK, that's a good suggestion because that's another way to bring in a case study and actually use it during the presentation rather than** immediately after. Is there anything else you would like to raise?
>
> (WBS FG3, 2009)

On reflexivity, Carver states 'the researcher may be changed by the process' (2017: 39) which mirrors how the reflection phases led to subsequent key changes to training content. Specifically, in relation to the diagrams, I had adopted the format of integrating vignettes of cases whilst presenting the diagrams as although I always verbally gave case examples, clearly this had not engaged them in the same way in their process of learning.

Initially, Robert's reference to a 'bottoms up' approach, I felt to be a problem, purely as a concern about the length of time I envisaged this could take. Obviously, a method with which I was familiar and used often however, in this

context, I felt anxious about the volume of material involved and what would be left out or not covered in sufficient depth. The full case studies were already conducted in this way, in triads in the counselling rooms as break out rooms, with time to consider, discuss and then all to bring back their deliberations to the full group. Yet, I felt his recommendation had merit and that I understood this meaning.

On-going reflection of the data around cases studies and trauma across the cycles, brought about a key change in material and delivery whereby I changed the initial focus from mimetically presenting the client's experience to actively engaging with their own cognition as the starting point, from which discussion could ensue about the nature of the bereavement and its impact upon the bereaved client group. Following a major reflection phase of the WBS participant data and in reference to that yielded by Claire's luminary transcript, I included and adapted Robert's suggestion by inviting future trainees to 'brainstorm' their thoughts as a collective group, as the actual starting point, for their cognitive processing. Below, I present the action points I took resulting from the WBS action research cycles.

4.3 Action points arising from the action research cycles at WBS

Organisational issues:

- Meeting with Claire to discuss:

- Use of GED1 – in common room for therapists to use with clients if appropriate
- Short term counselling – revisit earlier discussion and Claire to go back to supervisors
- Follow up meeting with trainer approximately 6 months after initial training
- CPD in-house on specific topics such as Attachment/ attachment trauma.
- Skills as an issue for trainees – relate to racial and cultural differences, specifically how to work with Black male clients: wider issue for training institutions. Recommend: Laurie/ Neimeyer paper 'American Africans in Bereavement: Grief as a function of ethnicity.
- Possibility of CPD for skills training in short term therapy
- Design and content of training programme and possible future implications for WBS in relation to identified new and additional needs to be included in an already full, fast paced, intense programme.

Training content:

- Increase neurobiological information and make available in written form to follow up on for themselves as a choice point for trainees.
- Increase information on Attachment theory – Bowlby
- Develop more case vignette materials drawn from real life situations to illustrate specific examples of grief reactions.
- Always use a proper pseudonym not, for example, S. – put Simon and write client in full, not clt. As an abbreviation.
- Provide a fuller Bibliography.
- When presenting diagrams, integrate the case studies they'll be working on to better explicate the theory, to better embed the learning, rather than introduce case studies after the presentation.
- Give a higher profile to the concept of maintaining emotional attachment and bonds to loved ones, link with Laurie/ Neimeyer paper and generate more discussion around cultural attachment and bonds.
- Use more vignettes of trauma materials i.e. smaller doses of trauma case material.

Trainee well-being:

- Increase psychic protection exercises / self-protective measures to mitigate against the toxicity of some of the more difficult material.
- Give a higher profile to self-care throughout

- Monitor more closely the impact of the trauma material on trainees on an on-going basis, not just immediately after working with this material.

Actions actually taken in response

Organisational issues:

- A two- hour meeting took place to discuss the action points which have resulted from this research. Preparation for this meeting was an agenda of the items for discussion, emailed in advance to the clinical manager to allow for preparatory thinking and reflection of both parties.

Training content:

- Inclusion of additional material:
- Written information on neurobiological functioning
- Remove input on PTSD
- Make more use of the U-tube clips 'The Animal Odd Couple' and 'Christian the Lion' to facilitate discussion around attachment (in preference to more written material on attachment).
- **Transcripts** have been produced from televised documentaries to illustrate loss and grief experiences and integrated into the training programme. These include:

  a) **Piers Morgan's Life Stories** with Cilla Black (ITV, 2009b), Katherine Jenkins (ITV, 2009c) and Simon Cowell (ITV, 2010a) which facilitate understanding and discussion of attachment and continuing bonds, the longevity of loss and grief and how the individual has responded to their bereaved experience. (Appendix 27)

  b) **Tsunami: 5 Year Anniversary** (ITV, 2010b) transcript to facilitate cognitive discussion around sudden, unexpected, trauma, traumatic death of adults and children: A disaster, already globally known through media coverage and already in their psyche, to prioritise their cognition and facilitate cognition (hippocampus) over emotion (amygdala). (Appendix 29)

  c) **9/11 102 Minutes That Changed America** transcript excerpts (ITV, 2009a) to illustrate elements of shock, disbelief and some of the realities facing people bereaved from or working with such traumatic events: A disaster, already globally known through media coverage and already in

their psyche, to prioritise their cognition and facilitate cognition (hippocampus) over emotion (amygdala). Also serve to bring in discussion of 'fire' scenes and being burnt alive, engaging them cognitively. (Appendix 30)

d) **Living with Murder** (ITV, 2009d) Transcript of parents whose grief is around the murder of their own son and the resultant impact on them individually, their relationship with each other and the whole nuclear family. Also illustrates a psychotic grief response. (Appendix 31)

- **Film clips:**
  a) **'Lethal Weapon 4'** (Donner, 1998): excerpt (with transcript) to illustrate the maintaining – enduring – of affectional bonds and emotional attachment to his deceased wife whilst in a new loving relationship. (Appendix 32)
  b) **'Shutter Island'** (Scorsese, 2010) a short clip to cognitively engage trainees at the start to avoid exposing them to 'shock' material and the risk of mimetic traumatisation. Their cognitive engagement is around the film character's bereaved thoughts and process, post death, not the fire scene itself.
  c) **Joan Rivers** - 'An Audience with' televised programme: to illustrate i) the lasting impact of bereavement by suicide (her husband's), the 'agonic switch' in trauma – as it occurs on stage – and the individual's capacity to live a full, successful life and recover quickly from later, agonic switch incidents; ii) the 'aftermath' (Ref. Rothschild's work) affect, related to her daughter's experience.
- Reorganisation of the training programme to incorporate the new materials and delivery of the content.
- Amended case studies with full pseudonyms, removed all abbreviated words and included a substantial Bibliography on Loss, Grief and Bereavement.
- Introduced on Day 2, the concept of maintaining affectional bonds and attachment in the group debrief following the 'Empty Arms' (3DTV, 1993) video and support this with a handout of selected transcript excerpts from the documentary.

- Designed a new diagram GED4 to illustrate the many diverse ways people find to remain attached to loved ones and included a section on pet loss which was informed by the Senior Veterinary Nurse who was a luminary to this research project.
- Piloted GED4 in the extended action research cycle E as a new diagram. This subsequently generated an accompanying diagram to cater for the loss of significant elders in our lives. These became GED4A and GED4B respectively, with GEDB aiming to capture a cultural dimension to attachment.
- Use GED1 to generate discussion of diverse theoretical orientations and their relevance to bereavement work, locating it with the research outcome of a trainee finding GED1 highly relevant in maintaining her own level of confidence in herself as a practitioner, rather than thinking her client had regressed because she was not sufficiently competent as a therapist.
- Incorporate case studies during diagram presentations to embed concepts in the learning, from the beginning (GED1) in reference to Celia Hindmarch (2010) article to illustrate real world experience of anticipatory death.

Trainee well-being:

- Begin to address this using the debrief sheet and question five which states 'How can we look after ourselves when working with this material?' Give this a higher profile to the group debrief and ways which would work for them personally, inviting suggestions and facilitation of group exercises throughout the training programme.
- Introduce from the beginning, therapist likely resonance with loss and grief and use GED1 to illustrate how this might apply to their own experience, emphasising the key issue is how quickly they recover rather than they have regressed into their own material. Continue to emphasise the normality of these incidents in relation to their own grief.
- Check at the end of every day, as usual, the impact of the material upon group members and ask specific questions about bodily sensations and intrusive thoughts. Continue to check daily, including on past material presented.

- Introduce a simple exercise to close each morning session and the end of every day irrespective of ‘material’ and following all trauma material, facilitated by group members or trainer.

Action points and actions taken which relate specifically to the training diagrams are presented separately below according to the definitive numerical order of the set of diagrams.

4.4 GED1: The Client’s Experience of Grief

This originated in 1992 not as a training tool but as a strategy in working with cancer patients and bereaved relatives who repeatedly reported distress at ‘going backwards’, ‘I’ve gone back to square one’, ‘I was doing really well and now I’ve gone right back again’. Such experiences were very distressing even depressing for people trying to emotionally recover from huge loss. When clients shared how they themselves were experiencing their grief process, I drew an upward diagonal line from left to right in the air and demonstrated drop off points to represent those times when they felt like that. Since they reported, and continued to report, how helpful they found and it made them feel better, I started to use it in training in 1992 as an intervention that could be used to help reassure patients and clients that each time they addressed a different aspect or remembered anew a part of their experience, they were likely to have the sensation of ‘going back to square

one’. In reality, however, it is dropping down from where they currently are and, once worked through, they arrive at a higher place on the steep hill to recovery.

> I was excited to witness a new way of thinking and to have explained ‘The Grief Psycho – Education Sheet: Normalising the Experience of Loss and Grief’.
>
> (WBS Validity Q, 2017; MSc Integrative; 5 years later; Appendix 24)

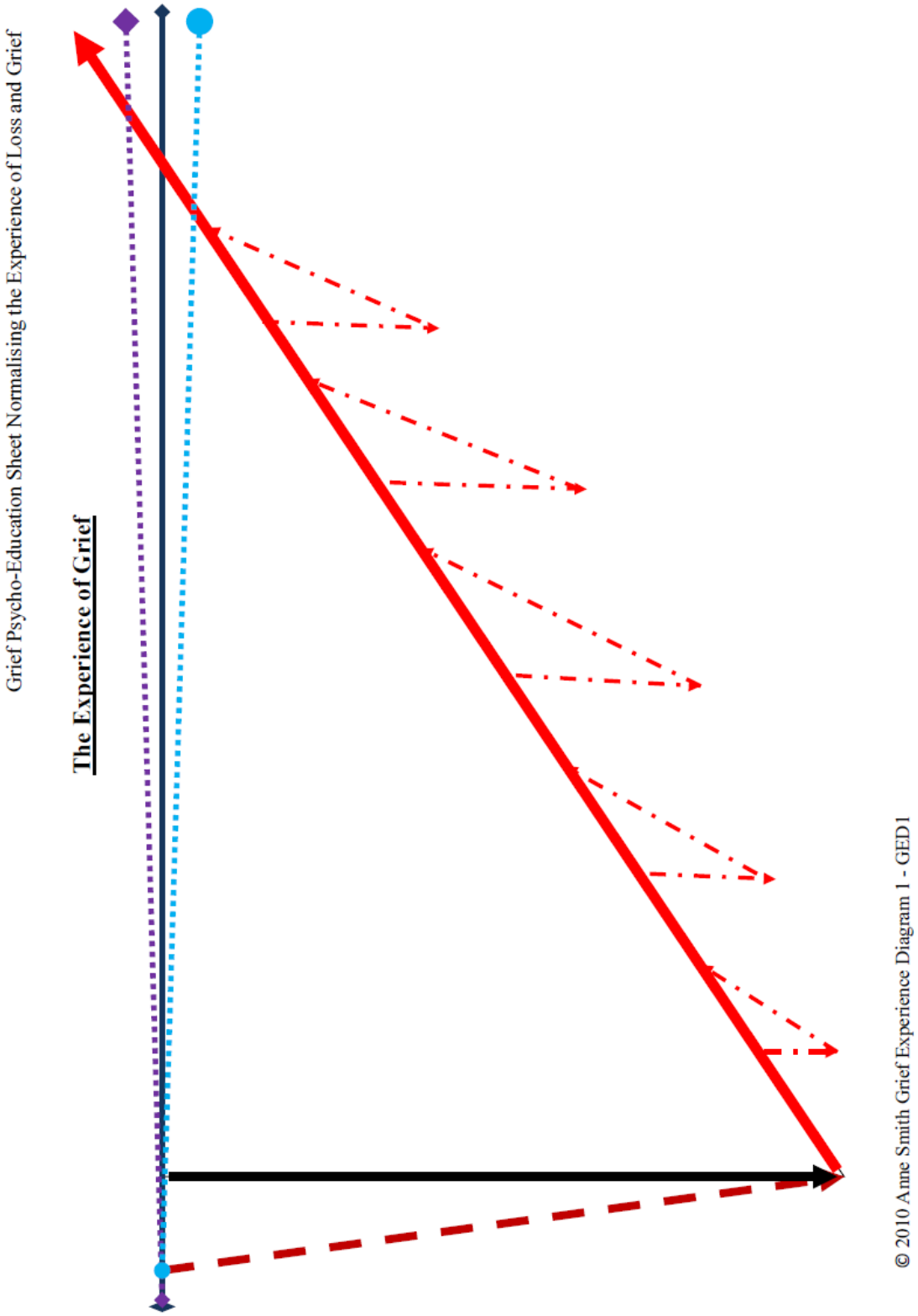

Grief Psycho-Education Sheet Normalising the Experience of Loss and Grief
The Experience of Grief
© 2010 Anne Smith Grief Experience Diagram 1 - GED1

FIGURE 18A

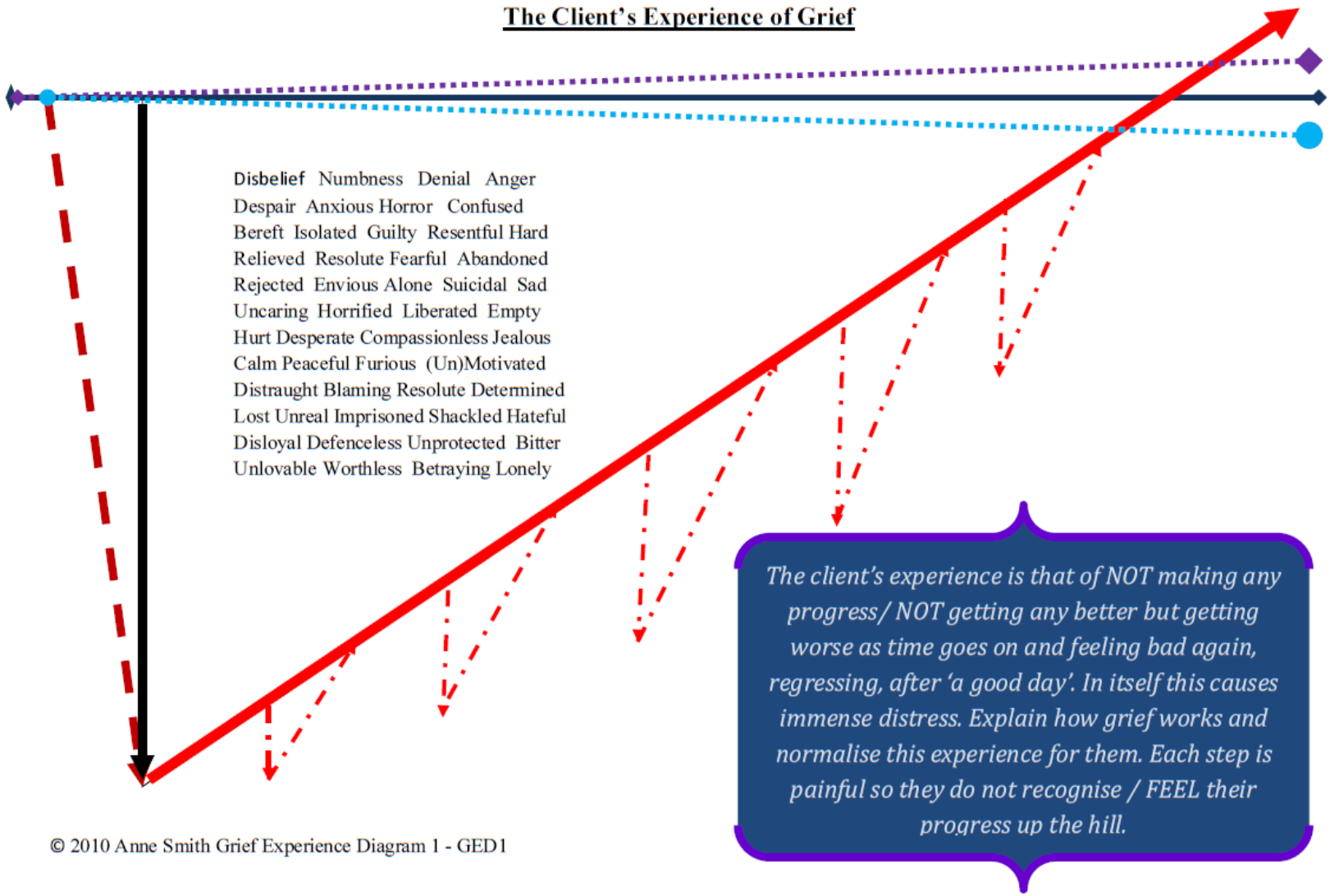

The Client's Experience of Grief
Disbelief Numbness Denial Anger
Despair Anxious Horror Confused
Bereft Isolated Guilty Resentful Hard
Relieved Resolute Fearful Abandoned
Rejected Envious Alone Suicidal Sad
Uncaring Horrified Liberated Empty
Hurt Desperate Compassionless Jealous
Calm Peaceful Furious (Un)Motivated
Distraught Blaming Resolute Determined
Lost Unreal Imprisoned Shackled Hateful
Disloyal Defenceless Unprotected Bitter
Unlovable Worthless Betraying Lonely
The client's experience is that of NOT making any progress/ NOT getting any better but getting worse as time goes on and feeling bad again, regressing, after 'a good day'. In itself this causes immense distress. Explain how grief works and normalise this experience for them. Each step is painful so they do not recognise / FEEL their progress up the hill.
© 2010 Anne Smith Grief Experience Diagram 1 - GED1

FIGURE 18B

The versions here are the definitive ones for training, having gone through several changes in both presentation and content. In a sense, they have come full circle as a result of the WBS action research cycles as much earlier on, my response to trainees' needs to ground the diagram in theory, led me to insert the traditional models of grief (Parkes and Kübler-Ross) as an overlay to the first diagram, along with Worden's tasks. This resulted in a visually complex and rather unattractive diagram which I continued to use up to the year 1999 until participants in the early PAC trainings gave me this feedback. Moreover, participants in the PAC trainings did not find the traditional grief models helpful or useful in their professional field as it did not fit with their experiences of prospective adoptive parents.

In essence, the early PAC and WBS cycles were nascent to my use of the client's first person phenomenological experience as a methodology for teaching. I took action by removing the grief and task models altogether and redesigned the diagram with the actual words clients used to describe their experience. Discussion with the social work adoption teams around the issue of 'Is it OK for a prospective adopter to still feel the loss of not having their own child?', led to the inclusion of the dotted lines above and below the horizontal line of the triangle to illustrate that at times the quality of life following major loss (of any kind) remains less than it was or can at times be greater in some cases. Apart from improving upon its presentation, it remained the same into the action research

cycles B, D and E with feedback suggesting its usefulness to both adoption teams in better understanding their clients' processes and to trainee psychotherapists in working with grief. A JMU student participant (Cycle E), also manager of a unit, working with self-harming adolescents, informed me that she used this diagram with the young people, having taken out the words in the middle and invited them to insert their own. This had proved effective for the therapeutic work with this young client group. In a later cycle E conducted with a JMU student cohort, a participant suggested this diagram equally applies to other presenting issues, particularly Depression and the process of recovery from depression and substance misuse where clients relapse and become despondent. A peer added this would also apply to clients battling with eating disorders.

Results from the WBS action cycles identified similar use by a former WBS participant who had returned to Greece. Her responses to the emailed bereavement questionnaire indicated her current use of the diagrams with clients and for teaching purposes (Appendix 16). I therefore enquired further into her use of the materials for greater insight as I was not aware of her professional activity and received this email reply:

> Hi –Thanks for your reply….i m glad to hear that you found my answers useful! 198eco been teaching in forms of seminars for both postgraduates in counselling psychology in City College in (names location in Greece) and also in schools and in an 198ecognized198i supporting survivors of cancer. The topics 198eco negotiated were mainly around Trauma (such as childhood sexual abuse, intergenerational effects of abuse) and Self care (such as the importance of parents taking care of themselves as a new way of caring for their kids-and of helping to build up their kids' self-esteem, self-

> care for carers and patients.
> (WBS Questionnaire participant: PhD Counselling Psychology; 5 years later.)

Response from a 2017 validity questionnaire implies use of the diagram GED1:

> Learning about the grief work models helped me be more comfortable with my clients as well as more understanding and therefore **more at ease with the many conflicting emotions they experienced.**
> (WBS Validity Q. participant: MA Cllg. & Integrative; 7 years later)

Similarly, a section from a focus group transcript (Appendix 19) indicates very direct application of GED1 with clients in the same manner in which I had originally used it and for the same purpose:

> Al. I do look at that diagram and I em, there's the em, I often think when I'm with clients , the sort of, the jumping, going up and down (*makes movements in the air to describe the 'drop off' points on the triangle of diagram GED1)*
> An. Yes
> Al. That, that diagram em, sticks in my mind a lot when I'm talking to clients and saying 'Don't ex (0.2), we're not on a straight line curve here. That I do think about jumping around.
> Br. I find it really helpful as well. And I **actually use that diagram with the people in the session.** I don't actually draw it out. Sometimes I think I should because there's something very (0.3)
> Al. Concrete. Yeah.
> Br. Concrete. Even have it, **we should probably have eh little handouts of it.**
> An. OK.
> Br And em. And I think **it speaks to people.**
> Al. Mm.
> Br**. I don't know if it relieves the pain, or it just gives a hope**
> Al. Mm. Mm.
> Br. But I don't see it as a false hope because [
> Al. No.
> Br. You are saying that actually you are working through that grieving process and there will be times when (*expresses sadness with facial expression)* but it speaks to them so **I use that one** (0. 6) (and nods a few times without speaking) **a lot**. And other ones that you were talking about and just eh, also the [ ] for me [
> ==========
> An. And I think Br. You used the word hope and I can see that.
> Br. Yes. **I've used it with almost every client.**
> An. Have you?

Br. Yes. At one point. **And they've found it helpful**. Definitely, definitely.
An. I heard you say as well that maybe we should have that in some sort of [
Al. Form.
Br. I think, I think that would be quite useful for people that feel comfortable using it**. To have it even in the office where we have the admin stuff.**
An OK. Well that's **like a recommendation you're making.** Would you (looks at others) endorse that?
Al. Yeah. Yeah I would. I think it is (0.2) I mean, I haven't used it. I've described the diagram around things but I've never actually given that to a client.
(WBS FG4: MSc Psychodynamic and MSc Integrative)

==========

Lewis: I found the diagrams particularly useful. Especially the diagram about the bereavement journey (GED1).
(WBS FG3: MSc Existential)

I also valued "drop-off" points adapting to bereavement;
(WBS Validity W, 2017; MSc Integrative; Appendix 23)

An outcome from the above transcript, determined after discussion at the two day validity cycle F with WBS staff (counsellors and supervisors) was agreement to produce copies of the blank client friendly version for the common room. In this way, the diagram is available for those therapists who may choose to use it in their client work for psycho-education purposes and is separate to the training version one naming diverse emotions associated with grieving.

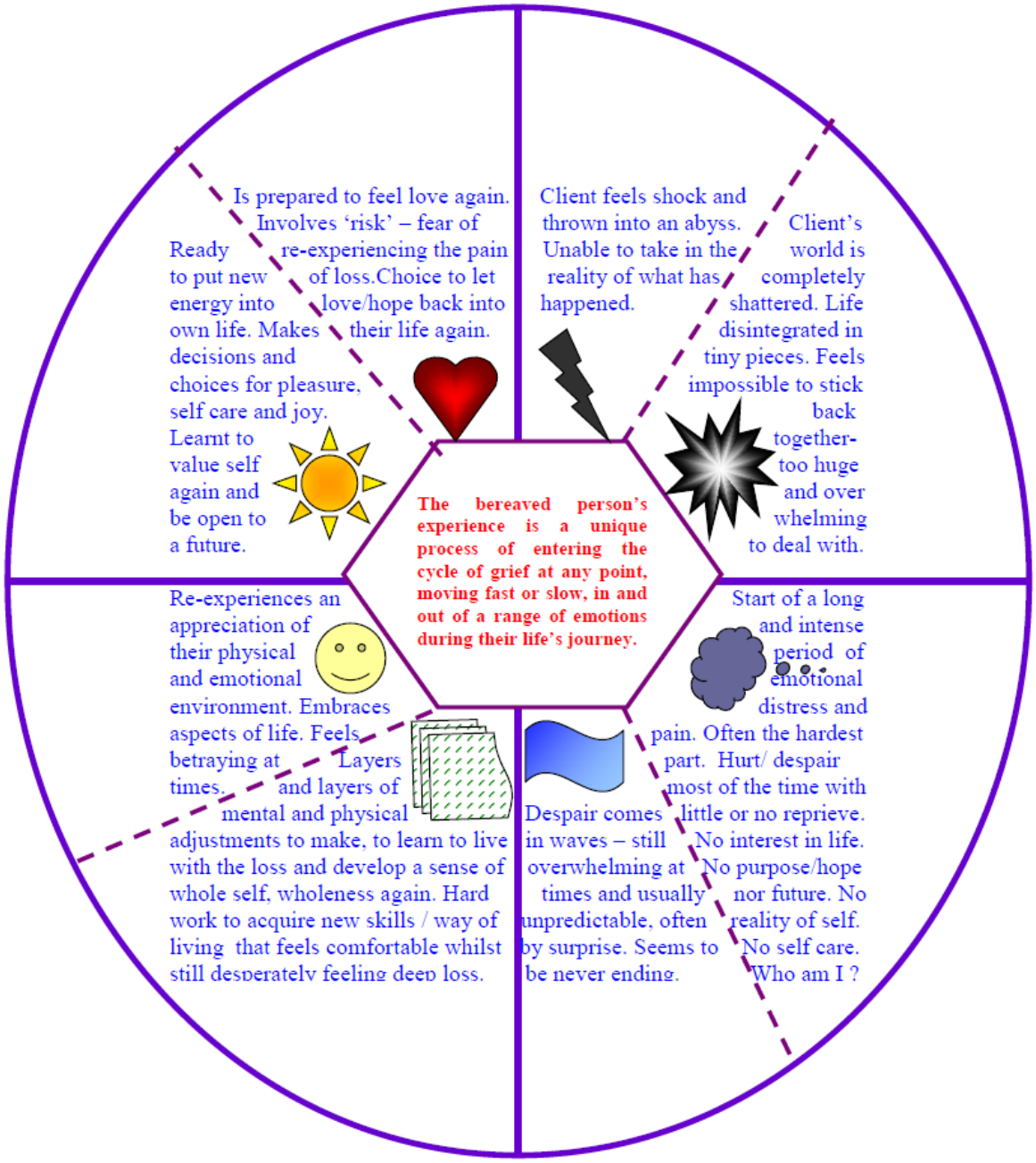
4.5. GED2: The Client's Unique Encounter with Loss

This diagram originated as a direct request from a PAC training with a social work assessment team. My remit for these trainings had been to address issues of loss and complicated grief which inevitably raised the question about suitability of applicants to adopt and the professional responsibility felt by the assessors for both the applicants and the child who would be placed with them. An added

dilemma was the issue of monthly performance targets set by the DOH for adoption approval, making this quite a socio-political concern which clearly, they as professionals, experienced most sharply. Adoption assessors encounter people bereaved through infertility, failed IVF treatments, multiple miscarriages or stillbirth who are, therefore, already emotionally vulnerable when being assessed for suitability. Following a long discussion with a team manager at the end of a day's training, I went away to design a diagram which would illustrate what a natural healthy grieving process would look like to assist assessors in identifying and feeling professionally comfortable with approving people when loss is still present, being experienced and felt.

I had already learnt from the social work teams that Worden's tasks of grieving appealed as being 'fit for purpose' and so designed the diagram in four quadrants representing Worden's four tasks. However, I applied client first person phenomenology to accurately and mimetically represent the experience of the bereaved by using words of their own and second person experience and interpretation of their meaning to capture their meanings within the diagram. Even so, I felt the four quadrants did not fully capture the lived experience and so sub-divided them to represent more fully the real experience as described by bereaved people (my clients) and added 'symbols' for each of the eight segments to enhance the meaning making process.

The Client's Unique Encounter with Loss & Grief



© Smith, 2010: Grief Experiential Diagram 2- GED 2

FIGURE 19

I presented this at the next PAC social work team training when we discussed as a professional group its applicability and usefulness to their assessment work. I also shared and discussed with them my concern that this diagram could become a substitute for the traditional models and interpreted equally as a given linear process to be applied universally. Discourse around individual uniqueness of the experience of bereavement, the grief process and the fact that two people in the relationship might well have differing experiences, led to a key adjustment: to emphasise the unique grief process by placing the client at the centre, touching all eight sections. This would facilitate a dipping in and out process, in different directions, rather than a linear process which would enable assessors to have a better understanding of a healthy grieving process.

Subsequent PAC cycles, following presentation of GED2, identified that professionally, they do not encounter prospective adopters at the point of their initial loss and grief and that their focus is to gauge if, as adoptive parents, they could provide a loving, safe environment where the child could flourish. The outcome was creative for their 'fit for purpose' use: to focus their assessments on applicants' personal capacity and resources to adjust to not having a biological child of their own and to welcome a new person into their lives as an individual; his or her own person. Thus the diagram also resonated with the experience that they frequently encountered in applicants who think no further than their own desires and needs for a child and have an idealised view of that adopted child

which fits with their expectations of a relationship with a birth child. Idealisation presents frequently and the focus on having the capacity to welcome a child who may well have loss and grief of their own, possibly rejection and abandonment issues, offered a measure for psychological readiness to adopt. This resulted in the development of an Assessment Model based on emotional and psychological readiness to adopt: 'Model to be adapted to encompass the team's own and statutory authority guidelines, policies and protocol' (Appendix 33).

Adopting this as a benchmark for suitability offered a workable outcome for them: no expectation for clients to be completely resolved about their own situation; no expectation for them to have stopped grieving for their loss and no expectation for them to immediately love the child. In effect, at the point of adoption, this is totally unrealistic as they haven't even met the child. Whilst the professionals know this, a difficulty they regularly encountered stemmed from applicants' anxiety about being rejected on the grounds that they are still grieving. The consensus was that this diagram helped to crystalize their conceptual thinking about what they were specifically looking for and gave insight into how they could initiate dialogue with applicants at the first meeting. That is, to proactively engage clients in the knowledge that their loss and grief does not preclude them from adoption. In effect, PAC participants reported that greater transparency around this topic had augmented the assessment process and created a more open and less defensive dialogue.

The interlocking Cycle B at WBS initiated a methodological dilemma within the action research. Appendix 35 illustrates an addition to this diagram of a time frame around the four quadrants. Although this had not sat easy with me, it was an outcome from WBS Focus Group 1 on the usefulness in having a time line guide in respect of Worden's 4 tasks for the therapeutic work. I therefore produced a new diagram and sought opinion at the next PAC training about this development. Not surprisingly, such a time frame would complicate their assessment process further and would in effect reinforce the concept of a set linear process as well as creating a potential for predicting a healthy/ unhealthy time frame of the grieving process. In addition, when I presented the new time lined version to the PAC ACE group, I observed to my dismay how participants grasped the time frame as a key to therapeutic work. My concern was that it would be used as a prescriptive measure or tool and would dictate the work (etic position) rather than therapy being dictated by the bereaved person's experience and emotional needs (emic approach). I took the decision to remove the time frame altogether despite having attempted to convey a broad time span across each quadrant. Further changes to GED2 had been to alter the wording in the centre to more accurately represent the very individual nature and uniqueness of the bereaved person and to change the title accordingly. A final change arose from the WBS staff cycle F, to remove from the bottom right quadrant the word 'worst' as in 'worst part of the journey' as this also is too prescriptive and is not true for all bereaved people even though it is for some.

Unprompted response on a validity questionnaire, 5 years post WBS training from a qualified practitioner, serves to support the removal of the time frame:

> There is no time frame by which loss and grief can be assessed and as such we cannot prescribe or diagnose a cutoff point. (Appendix 24)

4.6 GED3: Dimensions and Attributes of Compounded Grief

In effect, the action research cycles only produced one item response leading to an action change with this diagram and that was to include self-harm under the risks to bereaved people. Other changes made were from my own reflections not as a result of co-operative inquiry. Evidence for its content is supported by theory, my own practice- based evidence and participants during the training cycle who recognized particular attributes in people they know such as of loved ones, for example, an embittered attitude to life, social isolation and also instances of Tinnitus. In hindsight, the absence of trainee practitioners' contributions to this diagram is not surprising given that they are yet young in the field and I personally have only encountered psychosis as an extreme grief response on three occasions. The two luminaries concurred with this extreme grief reaction from their own clinical practice which does authenticate its presence in the diagram. It remains however, a much under recognized and under researched area. In the absence of participant contributions to the development of this diagram, I cite participants' later responses in support of its value.

I also valued risk factors for complicated traumatic bereavement.

> **Malcolm:** the continuity of the next one you brought in kind of overlapped with that which is pretty good. – The four sections so I thought that fitted in really well, when tasks of grieving are not met.
> **(WBS FG3;** MSc Counselling Psychology; at end of training)

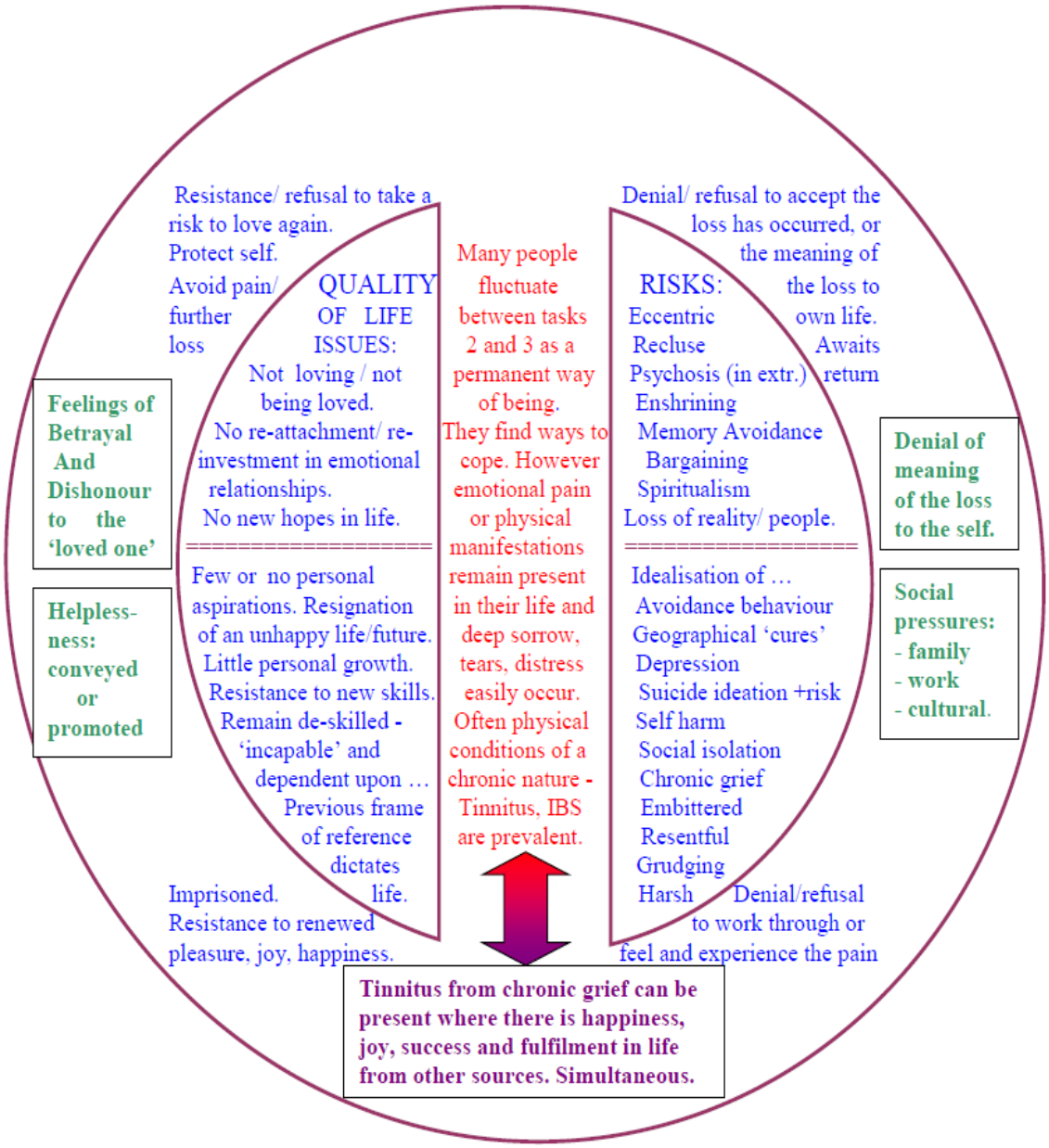
In respect of evidence for inclusion of psychotic grief:

> A paranoid-depressed client in his mid-50's who had experienced two family deaths (mum & dad) 8 & 10 years previously. He presented on anti-psychotic medication prescribed by his psychiatrist and had been referred by his GP.
> (Full narrative story can be found in Appendix 23 from 2017 Q.)

> The client whom I saw for 24 sessions while training at WBS lost her mother and it sounds as if she had a symbiotic relationship with her. My client was in her mid-50 at the time. Mother and daughter slept in the same room on twin beds close together.
> (Full narrative story can be found in Appendix 22 from 2017 Q.)

Psychotic grief is evident in existing literature and can manifest in different ways, as exampled by the participant narratives above; their contribution to this study occurring in the earlier part of this year, 2017. Considerable thought is required around this topic and I am aware that the examples I gave in initial training do not compare to the severity of the above examples. My immediate thought is that long term psychotherapy is appropriate and a priority over short term bereavement counselling. Both luminary psychotherapists concur that a psychotic process can result from bereavement and view this as clinically complex. In respect of this training programme, further reflection and consultation is required as to the feasibility and appropriateness of greater emphasis being placed.

Dimensions and Attributes of Compounded Grief



© Smith, 2010 Grief Experiential Diagram 3 – GED 3

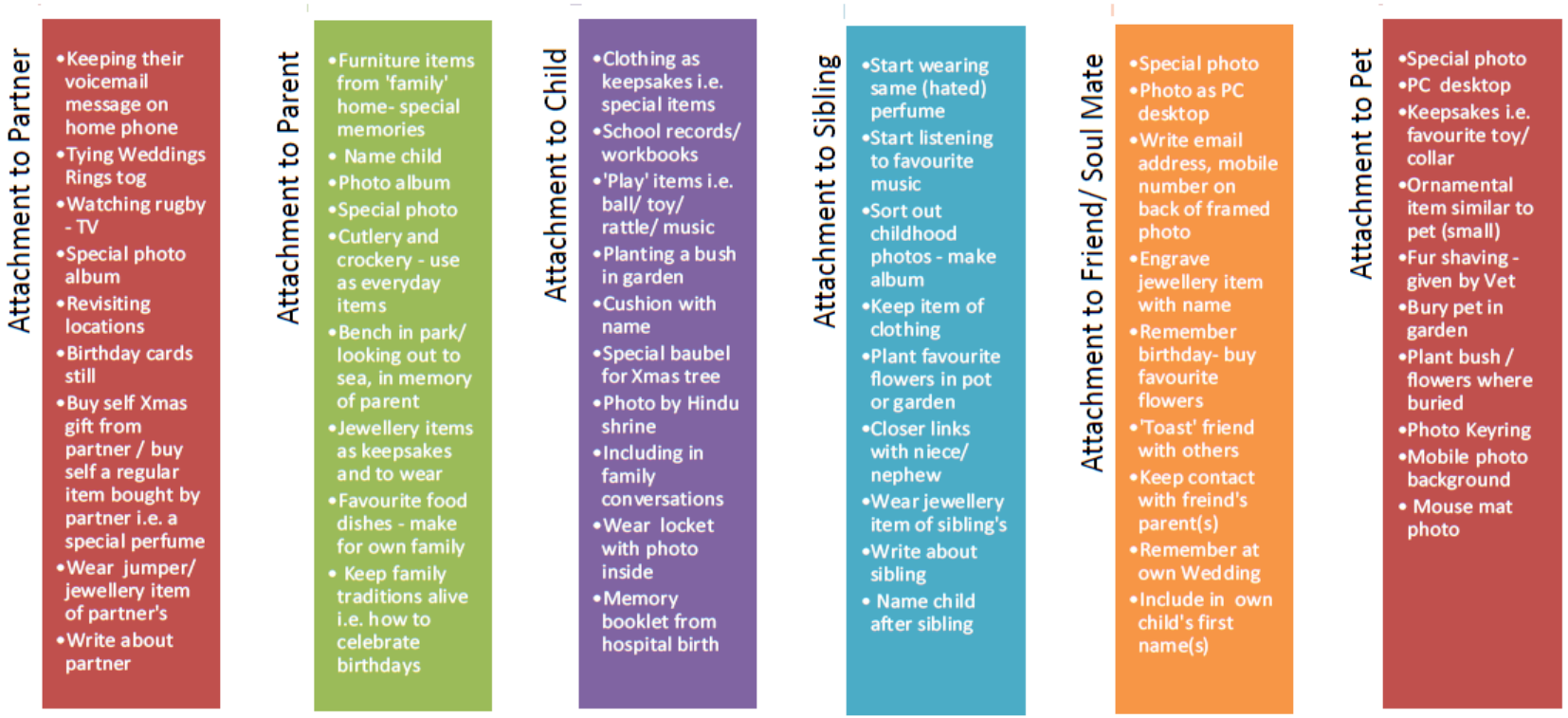
FIGURE 20

4.7 GED4A: Remembering, Not Forgetting

In the early reflection cycles looking at generated data, I became aware of the absence of any reference to continuing bonds or ways of remaining attached. I therefore took action to produce a diagram for the concept, entering the different ways in which clients had reported how they do this for themselves, some of which were also explicit within case studies used in the training, thereby reinforcing the concept of continuing bonds. A questionnaire respondent stated:

> The case-study materials, in my WBS training, and model of grief and loss that supports developing a new bond with the deceased I have found highly applicable to my clients' lived experiences of traumatic grief and loss.
> (WBS Validity Q. 2017, MSc Integrative; Appendix 23)

I included a contribution from the veterinary nurse luminary participant who described the usual practice of shaving a little piece of fur from a pet after death, to offer to the bereaved owner in case they wished to have this keepsake. Whilst some may choose not to, she stated it was ethical practice and taught in training as essential and, in the same way, asking if pet owners wished to have any items returned such as blankets, towels, garments. Her contribution was of a narrative nature where she described intolerable anguish for a few owners who refused to leave the surgery, or who collapsed on the floor in a fragmented state, their attachment to their pet being so close they could not bear to be parted from them.



REMEMBERING, NOT FORGETTING

© Smith, 2010 Grief Experience Diagram 4A (GED 4A)

FIGURE 21

Here, I insert a narrative section from one of the 2017 validity questionnaires as an example of traumatic pet bereavement (and likely psychotic process) related to the nature of the client's attachment to her pet dog:

> **WBS- traumatic bereavement following death of a pet.** I don't think emergency vet services in London are very geared-up to supporting newly bereaved. My client had a history of enmeshed relationships and class A drug abuse. She coped with her pet loss by wearing clothes, dying her hair, buying leather the same colour, phone cover, handbag, and painting her nails the same colour as her dead dog! Part of my work was to help her reflect upon how **this both supported her and was part of a pattern of over-identifying that made it hard now for her to adapt to her loss.** So raising awareness the impact of pet death is very important!
>
> (WBS Validity Q., 2017: MSc Integrative & Qual. Psychodynamic Counsellor; Appendix 23)

On a visit to France, walking through a cemetery, I noticed a saying on an epitaph inscription which read:

'Le temps passe, Le souvenir reste'
(Eglise, chemin du Mont Berti; noted 9/8/03 on 1947 Head stone)

and felt this was a lovely, endearing way to express 'aloud' the intention to remain attached through memories. Similarly, I came across a recent grave with inscriptions that resonate so well with the theory of continuing bonds and attachment.

Figure 22
(Cemetery in North East England; photo taken 19/11/16)

These words resonate so accurately with the ethos of diagram GED4A entitled 'Remembering, Not Forgetting'. Approaching the two people visiting this grave, they gave permission for me to take this photo for use in this document. The narrative 'story' behind the wording of 'Nana knee sore': a lovely example that captures the essence of how language plays such an important part in maintaining meaningful and 'enduring' relationships (Worden, 2010) beyond loss and death.

Figure 23

To distinguish between their Nana and great Nana, the grandchildren in this family when they were small, referred to great Nana as ‘Nana knee sore’ due to her having an operation on her bad knee. This term of endearment has remained and the family continue to refer to her as Nana knee sore.

After the initial development of GED4A, I subsequently piloted this diagram in an extended cycle E and encountered some distress and disapproval for having omitted a section on remaining attached to a deceased grandparent, creating a further action point.

4.8 GED4B: Cultural Family Bonds in Bereavement

This diagram was generated as a result of the piloting of GED4A with a JMU PG Diploma extended research cycle. One participant felt aggrieved that I had not included a grandparents section for attachment: she had had a very close relationship with her grandmother and also strongly felt that in Merseyside, families tended to have a very close family structure where loyalty, pride and support played a significant role. In the same group, a student of Japanese origin echoed her peer's view and added to the discussion in reference to 'elders' in the family and the respect accorded to them within her culture. This further led to discussion about the importance of ancestral bonds and how these inform and often dictate expected norms within contemporary cultural communities whether residing in the homeland or elsewhere in the world. A subsequent outcome became the expansion of the diagram to GED4B to include the importance and influence of elders and ancestors to the living, and thereby equally honouring non-Western cultures as well as families of all cultures which place emphasis upon generational values and relationships. In my reflection phase, I was reminded of the WBS Nigerian participant who had explained she would not dare attend her son's funeral if he were to die before her and of the practice of playing Dominoes during the nine night ritual for people of Jamaican origin.

I drew up a simple Venn diagram to illustrate the generational levels of cultural family bonds. On taking this back to the PG Diploma group, the Japanese student

contributed that for her, this expectation and attachment was not one she wished to engage with as it would likely rupture her intended and hoped for career path due to family duty and obligations regarding her elderly mother. Her contribution was and of course remains significant in putting forward both dimensions inherent in strong cultural and ancestral bonds and attachment. Here, too, it is relevant to refer to Laurie and Neimeyer's paper which identified: 'in the Africa-American community, the death of an extended family member may cause higher levels of distress than is seen in Caucasian culture' (2008: 189).

Cultural Family Bonds in Bereavement

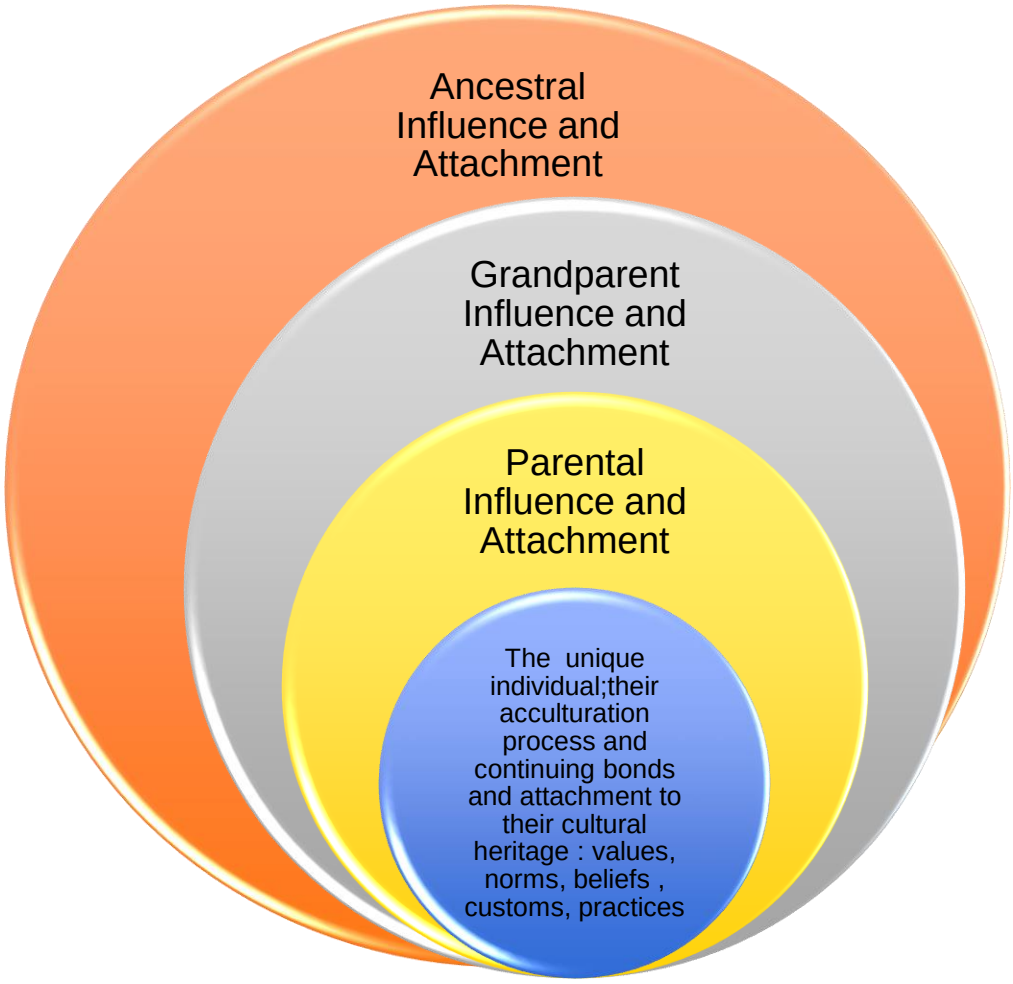


Figure 24

These two diagrams are presented together in training events and were used when delivering on the topic of 'Continuing Bonds' for the Wirral branch of CRUSE. Here, I present below excerpts from the evaluation feedback collated by the branch manager, the complete evaluation being Appendix 36.

1. **Has the course fulfilled your expectations?** Please comment

Learning about **the individual & idiosyncratic meanings to the bereaved, gave me more understanding of a person's need to continue a bond with the deceased loved one.** It has enabled me to be aware of the needs of the individual in their bereavement.

2. **Key objectives of the day were**

3. 1) To convey the significance and role of continuing bonds in bereavement and grief work; and
2) To enable you to confidently apply continuing bonds in your therapeutic work with clients**.**
How do you feel the training met these objectives? Please circle

Very well (**11) (11/11 responses)**

Will be a lot more confident encouraging continuing bonds clients show interest in and **reassuring them they are normal.**

3. **Please list what you found most valuable and interesting about the course**

Used contemporary films to illustrate her point. It was good to hear the outcome of a case history we studied, too.

Listening to Anne's experience. All her **examples were related to our work.**

The theory (I like knowing what the latest research is)

The group activities **– really learned a lot from working with other volunteers, very interesting to listen to how they do things etc.**

Real life case studies – also it was fascinating to see how much can be learned about clients from transcripts.

Diversity discussion

The **case study about a family affected by a murder and their individual reactions** was most insightful. Interviews by Piers Morgan and how loss impacts on a person. **Looking at the photograph of mourners after the death of Princess Diana – collective grieving & individual grief.**

Various methods used –all helpful; i.e. **DVD's, case-studies & transcripts all valuable. Small and large group discussions also very useful.**

Learning that **continuing bonds are idiosyncratic** – as individual as each bereaved person; and **knowing there is a fine line between remembering a loved one and being stuck in grieving process and being able to 218ecognize the difference.**

4. Please list what you found of least value and interest in the course

Nothing = 10

Too many photographs = 1

These collated evaluations support the value of both of the diagrams on attachment and continuing cultural bonds as suitable training material.

4.9 G (T) ED5: The Experience of Trauma

Motivation to produce an actual diagram explicating the trauma process arose following Jill Straker's (2004) specialist seminar on 15/3/04 which equally influenced my delivery of this diagram to include concrete examples of how a prior traumatic event can easily be triggered and also examples of how our survival instincts affect behaviour.

The initial diagram was relatively simple, however went through two further changes arising from the action research cycles. These are presented in chronological order.

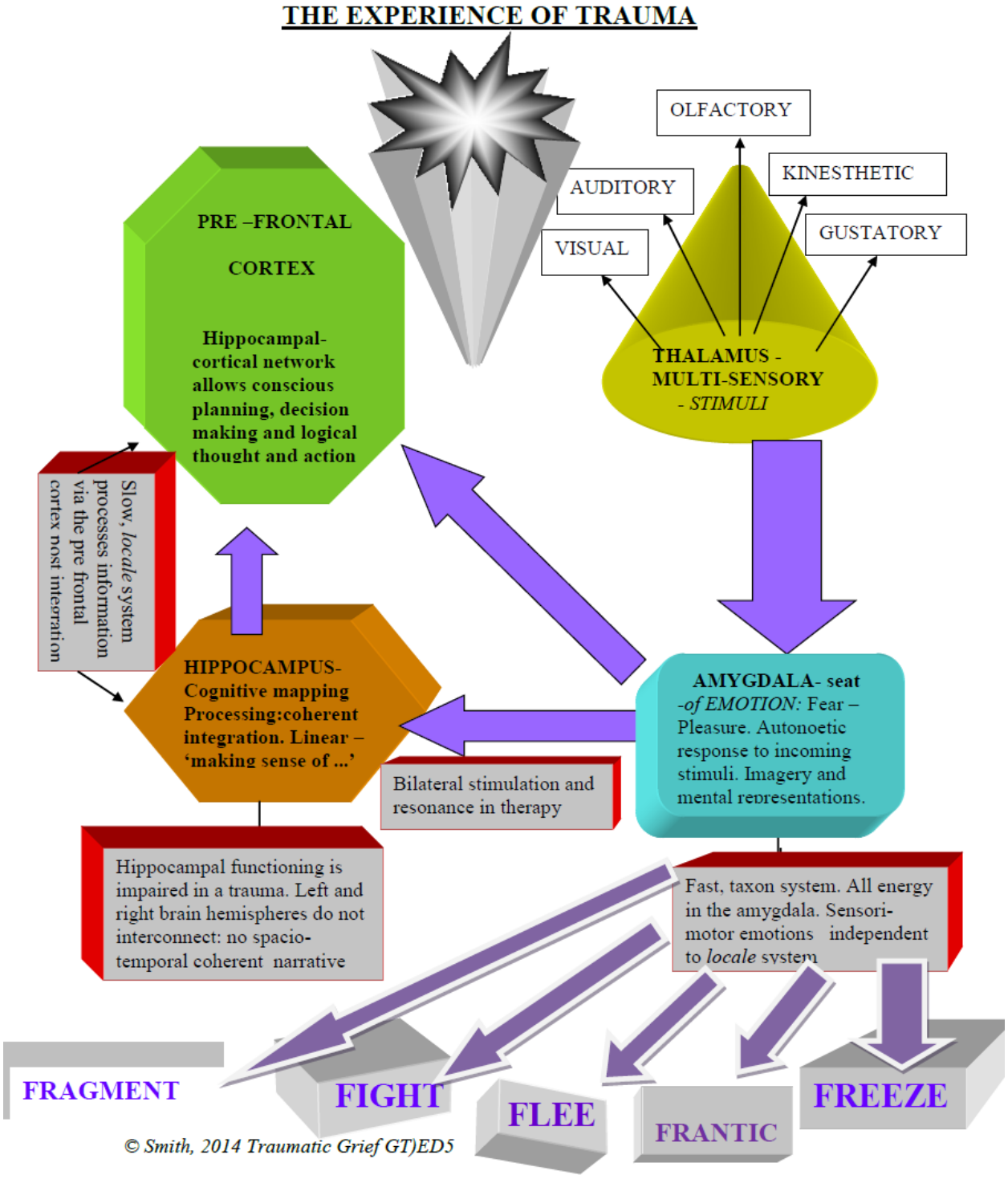

THE EXPERIENCE OF TRAUMA
OLFACTORY
AUDITORY
KINESTHETIC
VISUAL
GUSTATORY
PRE –FRONTAL CORTEX
Hippocampal-cortical network allows conscious planning, decision making and logical thought and action
THALAMUS - MULTI-SENSORY - STIMULI
Slow, locale system processes information via the pre frontal cortex post integration
HIPPOCAMPUS- Cognitive mapping Processing:coherent integration. Linear – 'making sense of ...'
AMYGDALA- seat -of EMOTION: Fear – Pleasure. Autonoetic response to incoming stimuli. Imagery and mental representations.
Bilateral stimulation and resonance in therapy
Hippocampal functioning is impaired in a trauma. Left and right brain hemispheres do not interconnect: no spacio-temporal coherent narrative
Fast, taxon system. All energy in the amygdala. Sensori-motor emotions independent to locale system
FRAGMENT
FIGHT
FLEE
FRANTIC
FREEZE
© Smith, 2014 Traumatic Grief GT)ED5

FIGURE 25A

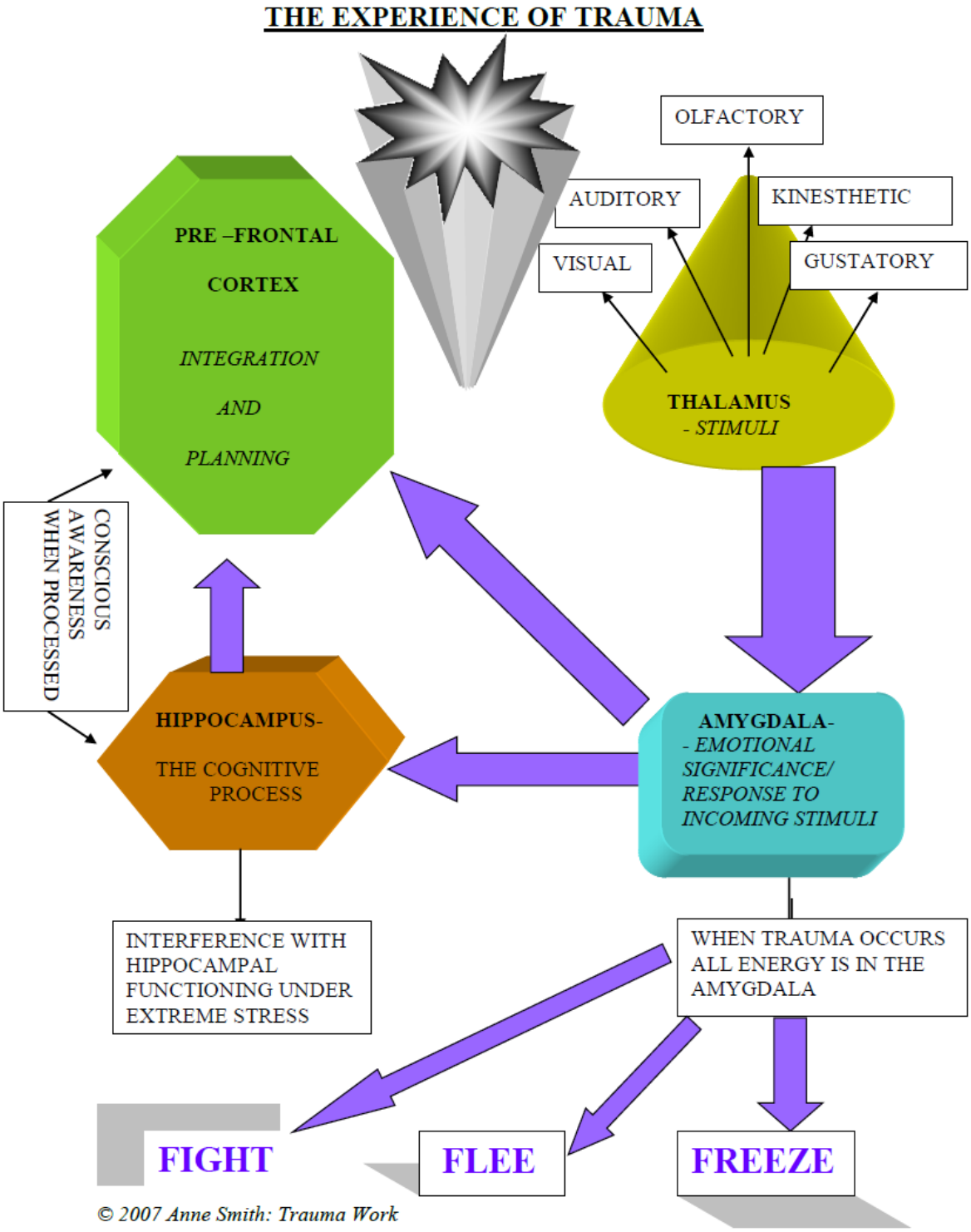

THE EXPERIENCE OF TRAUMA
OLFACTORY
AUDITORY
KINESTHETIC
VISUAL
GUSTATORY
PRE –FRONTAL CORTEX
INTEGRATION AND PLANNING
THALAMUS - STIMULI
CONSCIOUS AWARENESS WHEN PROCESSED
HIPPOCAMPUS- THE COGNITIVE PROCESS
AMYGDALA- - EMOTIONAL SIGNIFICANCE/ RESPONSE TO INCOMING STIMULI
INTERFERENCE WITH HIPPOCAMPAL FUNCTIONING UNDER EXTREME STRESS
WHEN TRAUMA OCCURS ALL ENERGY IS IN THE AMYGDALA
FIGHT
FLEE
FREEZE
© 2007 Anne Smith: Trauma Work

FIGURE 25B

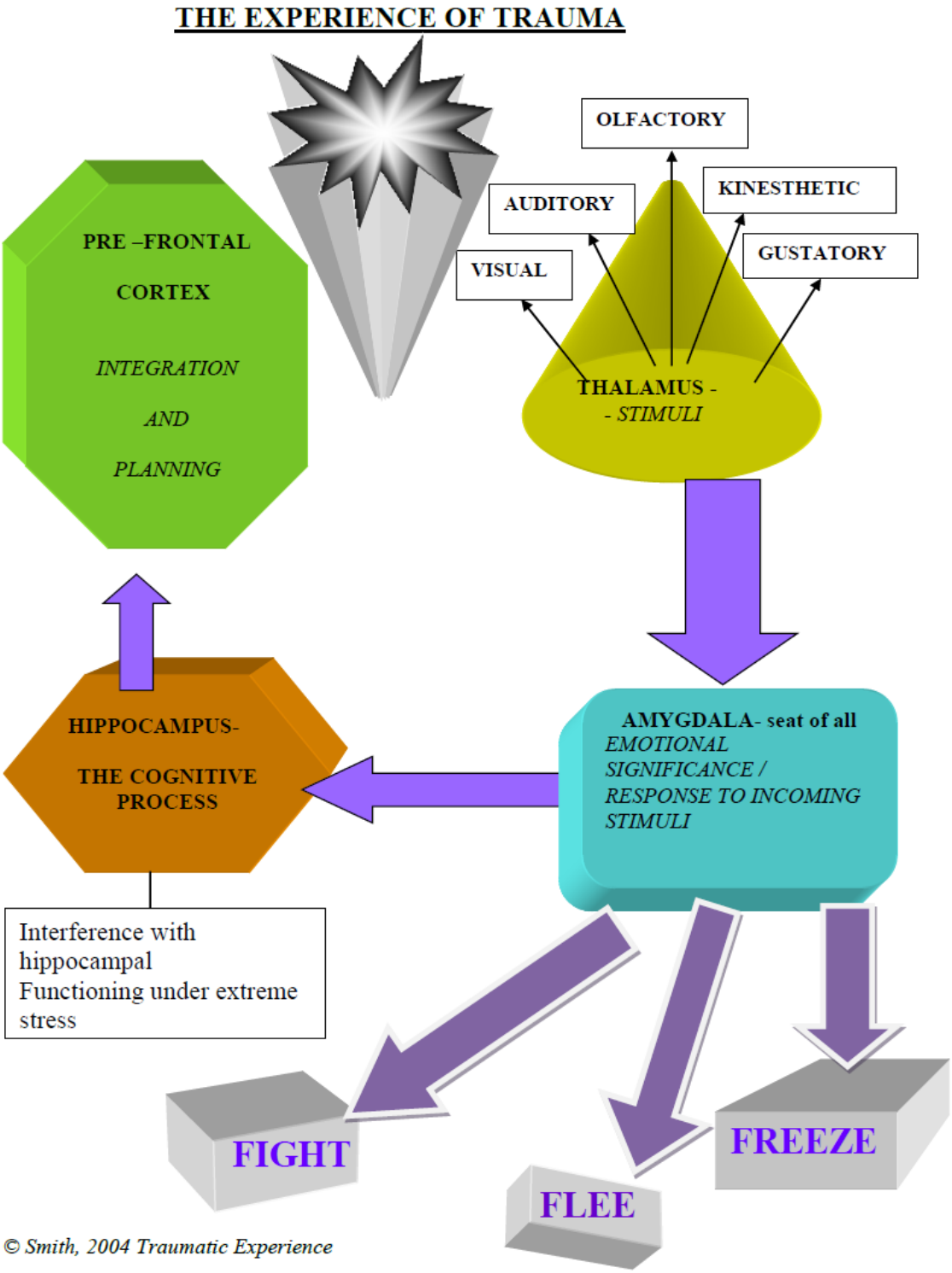

THE EXPERIENCE OF TRAUMA
OLFACTORY
KINESTHETIC
AUDITORY
GUSTATORY
VISUAL
PRE –FRONTAL CORTEX
INTEGRATION AND PLANNING
THALAMUS - - STIMULI
HIPPOCAMPUS- THE COGNITIVE PROCESS
AMYGDALA- seat of all EMOTIONAL SIGNIFICANCE / RESPONSE TO INCOMING STIMULI
Interference with hippocampal Functioning under extreme stress
FIGHT
FLEE
FREEZE
© Smith, 2004 Traumatic Experience

FIGURE 25C

The original was designed in 2004 and updated in 2007 following input from a research cycle where participants felt a more detailed explanation would be helpful. One participant in particular, a counselling psychology student, felt it was important to include an arrow from the amygdala direct to the neo-cortex where integration and planning takes place. This would facilitate the distinction between a person being able to act quickly to avert (further) danger and instances where the person is unable to do this due to a traumatic response. The box 'when trauma occurs all energy is in the amygdala' was also added to emphasise this distinction and to offer an explanation as to why people do freeze, flee or fight without thinking of the implications of these.

The definitive 2014 version is a result of trainees through the cycles wanting to have more information about neurobiological functioning: a deeper understanding of how it works in a trauma moment and how traumatic events can be retriggered, even years later. Since bilateral integration between left and right brain hemispheres lies within the training and is discussed in relation to the therapeutic process of bilateral stimulation and resonance of right brain to right brain, left brain to left brain attunement between client and therapist, participants suggested this be included to again, offer more detailed explanation. This included reference to the fast, taxon and locale systems to give further insight into what does happen and what does not take place immediately for someone in a personally dangerous, life threatening or vulnerable situation.

Additionally, the words Frantic and Fragment were added as trauma reactions based on descriptions of human reactions of exposure to traumatic situations rather than stay with the Flight, Flee and Freeze responses directly linked to our reptilian brain, replicating the animal survival instincts. A human being has access to a wider range of responses in certain situations which is more akin to frantic or fragmented behaviour.

As data outcomes had indicated that more written information would generally be valued, a power point presentation (Appendix 38) now accompanies the presentation of this diagram. The extended research cycle with the two paramedic cohorts at JMU on trauma, concurred that it would be best to include written information. One participant had said during my presentation: 'it looks like you've just enjoyed yourself playing around with different colours and shapes: it doesn't mean anything to me'. Reflexively, I remembered a WBS participant who said: 'I do remember them but I have to say if there's a choice between diagrams and numbers and words, I'm a person who prefers words' (FG4). Although the student's words had, to me, sounded quite harsh and highly critical at the time, in my reflection phase I recognized that it is a question of learning styles and how best individuals do learn. And perhaps, this individual felt very uncomfortable and annoyed in the session as the material presented was not helping him to assimilate information deemed to be important for his role as a paramedic.

Additional data from the paramedic cycle revealed the pressure placed upon paramedic teams. Officially, following a major or particularly traumatic event, they are entitled to 'down time'. In reality, however, this does not happen – a view reinforced, recently, by teams in North Wales. Generally, consensus about this diagram is that it aids understanding of the trauma process and that it addresses a highly complex process in a user- friendly form.

The luminary police officer has a professional interest in trauma and is also a Senior Investigating Officer trained in cognitive interviewing techniques. In conversation after the interview, talking about trauma, she found this diagram of particular interest for its explication of why and what happens during times of trauma for both the public and police personnel. She therefore took a copy back to the work place for its applicability to that work setting. Similarly, she found the phenomenon of Duchenne laughter to be really useful and helpful for herself and teams where this had clearly been happening, yet there was a strong sense of inappropriateness and discomfort about it and an acute awareness that, if witnessed by the public, there would be an outcry for disrespectful behavior. This, too, was reflected in the paramedic cycle, with similar experiences, thoughts and feelings.

In general, the findings are that the diagrams have considerable currency as a visual aide to training and that they retain their value post training to be used in on-going practice.

4.10 Child Nursing BA (Hons) cohort

An extended cycle involved a large focus group of 12 students from a child nursing course who had just completed a year of practice in different hospitals and were nearing the end of their three year course. They were part of the larger cohort of 24 to whom I had delivered a training on loss and grief, the year previous, towards the end of their second year.

Nvivo coded data was used, generating a coding model to illustrate their relationship to the four ways of Knowing and the four ways of Learning and Appendix 38 represents the Nvivo Coding summary report for the field notes taken during this 1.5hour focus group. The coding model illustrates the prevalence of 'idealisation', this being identified in separate dimensions of compensatory and protective idealization: a sophisticated concept pertinent to their professional experience. Below are some observations from their practice which they shared in the focus group:

> 'Too positive an approach from the medical staff – always put the positive about 'doing well', 'had a good day today' and not addressing the terminal nature of the illness.'
>
> 'No room therefore for parents to begin to address their loss and grief or work with anticipatory death. Observed unhelpful ways of dealing with and responding to family situations.'

> ‘In the professional role it is very important to patients to acknowledge relief at the death of a baby. This could reduce the guilt a woman or man might feel on being relieved if the baby has a medical problem or abnormality. If the professional acknowledges the relief, it’s psychologically helpful to the parents.’
>
> ‘Idealisation – you can see that with premature babies and following a difficult birth history and genetic defects. You notice it in how they treat the baby or child. They dress them like dolls! A child with a defect or very small, they will dress like a doll to over compensate or as a protection by making them look doll like and very appealing.’

From the discussion, they clearly understood compensatory idealisation to be associated with parents mitigating against the physical appearance of their own child as if to make them look more attractive, whilst protective idealisation was designed to ensure that ‘strangers’ would experience the child as ‘cute’ rather than be perceived as having physical ‘defects’.

In the coding model, informative learning is identified with diagram GED2 and poignant learning is identified with the U-tube clip, ‘The Animal Odd Couple’ with the consensus being that it had ‘opened their eyes to the loss experienced through illness and separation’ and how this relates to parents and siblings

visiting children in hospital. This had been highlighted even more through the seeing the joy at being reunited – Bella's tail wagging (a dog) and Tara's squeaky trumpeting (an elephant). They noted that daily visits aided recovery for hospitalised children as with Bella and Tara.

From discussion here, they highlighted professional implications for nursing patients in hospital and the implications for human relationships in relation to bonding and attachment, loss and attachment rupture in the case of long stay patients or heightened levels of emotional distress and loneliness.

The outcome from this extended cycle indicates the pertinence of the training materials used for loss and separation.

4.11 Midwifery Cohort

The session included students in year two of their course and those in year three, approaching the end and who had considerable practice on placement in hospitals and in the community. The focus was on the loss of a baby and centred on the Empty Arms DVD, with later, the U-tube clip 'The Animal Odd Couple' of Bella, the dog and Tara, the elephant. In respect of the latter, there was an intriguing moment when one of the students expressed anger at me for showing a video about animals as she hates animals and didn't want to see it. I did not follow up on this as her primary tutor was present in the room – (it was planned that she would be delivering this next time due to my resignation and the DVD had been copied for her use). It was more appropriate for someone who knew more of her

and her life to do the follow up. I just noted that fellow students did not respond at all and I merely said I recognized and appreciated that she found this video annoying. The group did, however, proceed to discuss attachment issues, as planned.

Due to the nature of their professional work, the death of a baby was not 'new' to them and hence discussion did frequently veer to the practical side and to professional behaviour, handling of different situations including miscarriage, debate and critique of some practices surrounding these instances, including that of other staff.

Response to the DVD section of the documentary where the family spend time with baby Emma who died a few hours after being born, clearly highlighted poignant learning, identified from their references to:

- Sibling Hayley (aged 7) stroking Emma's hair and head
- Dad Tony's involvement and being included in the whole process.
- When Yvonne was going to hold baby Emma and at the last moment couldn't and pulled back in emotional pain and distress.
- Leaving the hospital without a baby; came in with a baby and leaving without.

However these responses came from a minority of the trainee midwives with the majority preferring to focus on information regarding registration of baby death and joint baby funerals, usually organized on a monthly basis by the hospital bereavement officer, when parents choose to leave their dead baby to be looked after by the hospital. Here, then, evidence of informative learning enhancing practice

Chapter 5: Discussion

5.1 First insights

To address this section my initial focus lies in relation to a degree of perplexity I encountered regarding cultural inclusivity throughout the programme. Evident were conflicting accounts between participants' experiences of the training content and their experience of the actual therapeutic relationship and process, with specific reference to Asian and Black male clients. This highlights a disparity between knowledge gained through the fourfold ways of learning (Experiential, Poignant, Generative, and Informative) and its application to practice. Evident from data, is a sense of inadequacy, analysis of which initially came across as an inference from participants that the difficulty encountered in the therapy room stems from the clients' ambivalence or difficulty in communicating their feelings. A surface level counter argument to this is that many white British male and female clients present in the same way, yet this was not flagged as an issue. Yet deeper reflection led me to wonder whether participant experiences arose more from a sound awareness of the importance of cultural differences of language and socio- political, cultural perspectives and hence, feeling less confident alongside a strong desire to 'get it right'.

Multiculturalism has been defined as a term to 'be used to identify educational and training practices in which trainees address race, culture ethnicity, language, socio-economic status, gender, lifestyle, age, religion and ability' (Gloria &

Pope-Davis, 1997: 244). In part, I felt perplexed as the training clearly had promoted ‘an environment in which dialogue about multiculturalism’ (ibid, 249) had taken place whilst also being supported by specific case studies, experienced and evidenced by participants as significant and ‘helpful’, as well as the physical environment itself with many multicultural artefacts in the building. ‘In providing a cultural ambience or cultural learning environment for counsellor-in-training, it is imperative to realize that diversity is a reality and is more than a value system’ (ibid: 253). ‘Providing a culturally sensitive ambience’ (ibid, 256) is what WBS does and yet I was aware that all the WBS participants in this study were white, as am I, despite there being many non-white counsellors at WBS. I believe this reinforces within existing literature, the issue of white supremacy and how this remains pervasive within the field of counselling and psychotherapy, with much yet to be achieved beyond providing a culturally sensitive ambience. Reflecting on this, I realise a level of complacency on my part due to the belief that because the training incorporates many cultural artefacts and case studies capturing the diverse ethnicities within Wandsworth Borough, that this addresses the issue whereas of course, it is altogether far deeper and more complex. I found this outcome to be a challenging truth and one which persists today.

A second observation is that many participants referred constantly to the ‘stages’ of grief despite the fact that since I personally am opposed to this notion, I never refer to stages in my training on grief other than to critique traditional stages of

grief. The frequent reference to ‘stages’ in the data suggests that the diagrams are understood as theoretical models in themselves, posing the argument that I am perpetuating the idea of a theoretically driven epistemology rather than promoting an epistemology of bereavement in order to fully meet the whole of a client’s experience: the original intention. That the diagrams have been valued for their usefulness and benefit to practice is evident ideally, however, further research conducted by trainers other than myself as researcher, would more accurately determine their value and contribution to the field.

On the effectiveness of training, results from a luminary interview with a supervisor did evidence acquired competency; practical knowing of WBS trainees in therapeutic work with bereaved people.

> ‘You facilitate it for them and they are much more equipped in working with that in an effective way. They are more available to the client because they have a personal sense of their own grief experiences being normal. Their therapeutic work is effective as a consequence. Other supervisees/ trainees are less comfortable with those dynamics. They are more hesitant and reluctant, including around the recovery concept’.
>
> Question: Are you saying there’s a difference between (0.3) that you notice a difference between those who have had WBS training and others who haven’t?
>
> ‘Yes, definitely. It’s very obvious to me. Others aren’t as open to the client and don’t have the same awareness or knowledge and are not as confident in working with bereaved clients. They are more hesitant and reluctant to

> engage relationally and, as I said, including around the concept of recovery.' (Luminary supervisor.)

Emphasised in the above is the therapist's availability and personal capacity to work relationally with bereaved people. This supports the outcomes indicating that experiential learning has been a significant component to the training to which they attribute personal meaning and growth.

Consultation with the WBS manager as a luminary and with the staff group, further confirmed the effectiveness of the trainees' practice with the reporting of one exception where it became apparent that the particular counsellor's work was informed by previous training in the traditional models of grief. The consensus from participants is that the training is very comprehensive and they feel prepared to undertake the work. In reference to my former student who contacted me by email when undertaking the WBS training delivered by Claire, she reported:

> 'I wanted to share with you that everyone (which includes me) fed back to Claire today that they thought the training at WBS was outstanding, extremely enjoyable, thorough, well-structured and it was the best training they have ever received from a placement. They all felt really held and supported by all the information provided (we really did get a lot of handouts which were all very useful). Everyone said that because of the intense and thorough training it meant that they all felt ready to start with their clients.' (Sent 12/10/15 @ 16.52

Her content infers continuing value of the training when undertaking bereavement work.

Reflecting on the diagrams, these have proven appropriately informative and useful however, Dimensions and Attributes of Compounded Grief requires further consideration. Reference to IBS has been removed since there is very little evidence for associating this with loss and grief. Tinnitus however, remains as there is evidence despite this not being substantiated through other sources such as an RCT trial. Further, there has been corroborating evidence with identification of new instances following bereavement. Also of significance, its reoccurrence for two individuals, a past client of WBS and a former WBS research participant. This remains of clinical interest to me and it is my intention to investigate this further.

5.2 Training content overview

Outcomes indicate several strengths of the training content which are conducive to learning and to the acquisition of acquiring levels of competency when working professionally with bereaved people. Further evidence suggests it is reasonable to assume applicability and transferability of training materials to other professions.

The action research process generated an exchange of knowledge between participants which was of mutual benefit to all parties, promoting deeper insight into their professional roles, their respective responsibilities and implications for practice and bereaved people. Knowledge of loss and grief processes was found

to be of benefit to other professionals in a way which informed and supported their own professional role through diagrammatic materials and specific concepts such as interpersonal and intrapersonal meanings of loss, attachment and traumatic bereavement. Equally, psychotherapeutic work with bereaved people has been enriched through significant sharing of their professional knowledge and expertise, ranging from the practical to the legal and their inter-professional relationships.

5.3 Inter-professional relationships

All sudden, unexpected, violent and traumatic death, and deaths which occur in custody or a work context must be referred to the relevant Coronary Office irrespective of apparent cause, thus placing Coronary Officers in a central role with the Police and the Hospital both feeding directly into the coronary system. Discreet professional relationships are maintained with other stakeholders: the HBO with Registrars, Funeral Directors and Housing Officers; the CO with a police Family Liaison Officer (FLO) and Senior Investigating Officer (SIO).

Analysis of their independent interviews have highlighted the inter-connectedness of multiple professional roles in the case of a sudden and unexpected death, in turn identifying the different professionals with whom the bereaved need or are required to engage in the immediacy of the death of a loved one.

Additional findings from the CO and PO interviews corroborated clients' statements in respect of being shown photographs and CCTV footage of events leading up to suicide and accidental deaths, Road Traffic Collisions (RTC) and unlawful deaths. Such visual material causes great distress to the bereaved and in my practice I have noted how those clients have found it difficult to decline to view them. My psychotherapy practice experience is contrary to the PO who in interview reported 'the ones I've been to, the family have always opted out; they go and sit in a side room'. A reason for this may be that I refer back to clients in my London practice where the CCTV footage has been connected with incidents in the Underground involving the British Transport Police and the interviewee is based in the Merseyside area. One of my clients, however, was informed that photos had been taken but were too horrific to be shown. The client did not need to have that piece of information especially as the taking of the photos was unknown in the first place. For the same client, there was a 12- hour delay in being informed despite having gone to a police station to report a missing person and being advised to go home. It later transpired that her partner's death on the tube was already known at the police station where she had enquired however, professional protocol required that the 'death message' be delivered by the Transport Police.

Here, I am reminded of clients whose traumatic reaction to a bereavement arose from the aftermath of a tragic event rather than the death itself. Grief is often unnecessarily compounded by the way in which some professionals engage with the bereaved and I could relate this to the institution of the hospital, British Transport Police, Coroner's Office, and pathologist reports.

Data yielded by the Coroner, Hospital Bereavement Officer and Police Officer identified a lack of specific relevant training for and within their role and, further to their experience, inconsistencies within the respective institutional systems of their professional work setting. I learnt how all three professional roles will vary in manner of functioning from one work location to another, dependent upon the individual in post and the institutional culture, rather than also taking account of the emotional and psychological needs of bereaved people as well as fulfilling the legal duties and responsibilities of their role.

Further, discussion with all three luminary participants highlighted the lack of emotional support they receive in carrying out their respective duties, even when dealing with particularly distressing and traumatic scenarios. There was recognition of 'overload' in respect of the police FLO role whereby if someone red lighted, they took a break from that particular side of policing however, no

such caveat exists for the other two roles. Whilst this has remained so for them, Police Forces throughout the UK have augmented their occupational health services, with officer well-being given a much higher profile. As an added point of interest, in my current practice I am mindful of Compassion Fatigue (Figley, 2002) and Burnout (Pines and Keinan, 2005) and have drawn upon studies which specifically relate to stress and traumatic factors for Officers in the line of duty (Miller, 2008, Miller, 2007, Miller, 2006, Mitchell and Levenson, 2006).

I noticed how, independently, all three luminaries were quick to grasp at the relevance of the phenomenon of Duchenne laughter and respond to it with a genuine sense of relief and interest. They immediately understood its significance, adding non-shaming meaning to their own and others behaviour when encountering scenes which violate our norms; things that shouldn't happen, that are not meant to happen in life, that are a violation to our own values. When appropriate, I now refer to this in my current practice and have found it to be therapeutically conducive on each occasion I do so. Offering an explanation about the specific psychological function of Duchenne laughter to reduce emotional distress or prevent traumatization through social bonding and laughter, normalized their behaviour and made a difference to self-perceptions they had privately harboured.

5.4 The neurobiological influence

I am aware that a neurobiological lens is a contentious issue within the field of counselling and psychotherapy in general and more so in respect of bereavement therapy however debate seems to be polarized, paralleling the opposed epistemologies between a purely phenomenological and a scientific stance. Langdridge (2007) holds firmly within the pure phenomenological paradigm, dismissing all reference to neuroscience, for example addressing comprehensively the noetic processes of 'noesis' and 'noema' (2010: 14-15) without reference to the neurobiological functioning and its location in the amygdala in the right brain hemisphere. Conversely, Siegel positions himself as a neuroscientist as does Cozolino, both of whom explicate and promote the significance of neurobiological functioning of mind and body to emotional processes. Rothschild, Etherington, van der Kolk, and Levine all place significance on the relationship between mind and body, psyche and soma, in the therapeutic endeavor. Van der Kolk's seminal paper 'The Body Keeps the Score', has influenced and informed later authors and practitioners on working with traumatised individuals, whilst Rothschild and Siegel advocate caution on the re-triggering of the original trauma during therapy. Rothschild frames the caution as 'putting on the brakes' and for her teaching of trauma on U- tube, she equates the desired optimum therapeutic process to the careful, graduated

opening and shutting of a carbonated bottle of Coca Cola. These theoretically informed concepts make sense and pertinently add to the debate in favour of an underpinning of neurobiological understanding to the client's internal processes and thus the therapeutic process.

From the person-centred perspective, Lux (2010) takes a middle ground position identifying the client process within his PC theoretical orientation, integrating this into an interpretation of neurobiological functioning whilst Gergen (2015) criticizes the use of brain scans and especially pharmacology when questioning the prevalence of neuroscience, as though that is all that is involved in neuroscience, a somewhat myopic view. In line with Lux, I adopt the middle ground, taking from neurobiology what it has to offer in terms of gaining deeper insight and understanding of internal processes for therapeutic gain,

5.5 Was the methodological choice appropriate?

Action research was an appropriate methodological choice for an inquiry into training activity for the purpose of involving trainees in the development of a training programme. The interlocking cycles and use of luminaries worked well to enhance the inter-professional dimension to the study and give a broader perspective on the whole meaning and experience of being bereaved.

Outcomes of the action cycles did inform the development of materials quite extensively in both diagrammatic and written form and identified a greater need for therapist self-care throughout the whole programme. It further led to the emergence of the concept of 'mimetic traumatization' as a distinct phenomenon from vicarious or secondary trauma and occurs from exposure to material which imitates scenes of a traumatic nature. Impetus for developing the diagram 'the client's unique experience of grief' (GED2) came directly from the statutory Social Work Adoption teams to assist them in their role as assessors of prospective adopters whilst the cultural family bonds diagram (GED4B) was generated directly from student participant critical feedback. Follow up with the PG Diploma cohort on this, identified an added dimension of significance for individuals for whom cultural and ancestral bonds are experienced as oppressive and non-conducive to their own aspirations. Here, I make a connection with idiosyncrasy and see this as idiosyncratic experiencing whereby an individual does not embrace the collective, cultural norms, values, beliefs and societal views of their ancestral heritage.

Heron and Reason's 4 ways of Knowing lent itself well to identifying the appropriateness and effectiveness of teaching materials for training bereavement therapists and led to a research generated matrix with 4 ways of learning. The relationship between them explicated the meaning of specific materials to the learning process and is identified as a TLQ matrix (Teaching, Learning Quality).

(The TLQ (blank version) was presented as an ipsative, formative self-assessment tool at a JMU Teaching and Learning Conference for use by Academics with their cohorts and received a favourable response.)

One action cycle revealed a necessity for skills training in respect of working with Asian and Black clients, and more specifically, Black male clients, as previously highlighted. Though unknown, it is possible that another methodology may not have uncovered this revelation.

However, the action research approach, or my approach to the action cycles did not lend itself to data in respect of the proposed transtheoretical approach. In effect, very few references were made about theoretical orientation, the most significant one being in reference to having a developmental approach as an integrative psychotherapist. There is no indication in the data that orientation proved problematic within the training groups and, indeed, they enjoyed learning from one another about different modalities during break times. Although that is so, it does not substantiate this being a transtheoretical training. This is critiqued later on.

In addition, there were some difficulties with focus group composition. Litosseliti (2003) suggests that similar levels of professional competence are more likely to encourage focus group participants to speak in an open, transparent

and spontaneous manner on the subject in question. Mixing different levels of competency are likely to produce more restrained responses. In contrast, McLeod (2003) suggests that different levels of experience might help to augment results. I found different levels of competency or perceived competency, to be counter-productive to truly open discussion. Morgan (1997) discusses the strengths and weaknesses of focus groups, warning of 'idealised accounts' (1997: 20) from participants and group conformity.

> 'The concerns for focus groups include both a tendency towards conformity, in which some participants withhold things that they might say in private, and a tendency toward "polarization" '(Morgan, 1997: 15).

He identifies a further weakness concerning 'the ability of any particular set of participants to discuss a particular topic. One set of problems involves topics in which the participants' level of involvement is either too low or too high' (Morgan, 1997: 15). In a similar vein, Schwandt (2003) speaks of the inter-subjective world of the individuals in the focus group and Punch (2006) speaks of the essence of their phenomenological experience.

A key factor in facilitating a focus group is the protocol adopted for the process. On the issue of interviewing, Creswell (2009) proposes no interview protocol, whilst McLeod (2003) suggests semi-structured interview questions with the use of prompts to assist interviewees in answering the posed questions. My

preference for both individual interviews and focus group facilitation followed Wengraf's (2001) proposal to use prompts which relate to the main research question.

Undoubtedly there will be barriers, conducive factors or personal agendas which will influence how easily or not participants discuss the topic of researcher interest. One factor is the number of participants in the focus group. There appears to be no definitive, optimum number although 12 participants is clearly stated as the maximum number. Silverman (2007) states 3 to 12 with 8 to 10 people being the optimum number and McLeod (2003) proposes 7 to 12 as an ideal number. Morgan (1997) advocates a smaller group size of 3 for the more concentrated and in-depth discussion this will generate between the participants. He further points out that deviant cases are more evident in smaller groups for their lack of contribution.

Outcomes indicate that experiential learning has been a significant component to the training to which they attribute personal meaning and growth. Adoption of the 4 ways of Knowing and the TLQ matrix were central in explicating the experiential component and a luminary supervisor's contribution strongly supports the data evidence from participants. In addition, I add some feedback from PG Diploma students:

PGDip 1: You have shared yourself as a person and your experiences and have a great honesty and genuineness about you. Thank you.

PGDip 2: Your heart – when you shared your experiences with a client who was dying – you gave us such a gift that day and generally of speaking from your whole heart.

PGDip 3: Anne, you have a nurturing and encouraging way about you. I sense you are open-minded and courageous… and very knowledgeable. Like your groovy jewellery too!

The significance here is concerned with the tutor modelling the value and relevance of being open to learning from experience and being in tune with our own personal experiences. Charlesworth wrote: 'when self-disclosure is well used, there is a positive sense of connection between the individuals concerned, whether [] or tutor and trainee' (2016: 31). In the training, I profile the role of the therapist in holding the hope for those who are unable to hold hope for themselves in their time of deep grief and sorrow and I think it is this which 'speaks' to trainees.

5.6 Ethical considerations

The ethicality of this project was approved by Middlesex University and the Metanoia Institute when I presented my LA to the panel and submitted my written proposal, along with the required signed consent forms by the official signatories to the research activity. However, ethical dilemmas most frequently emerge during the research proper and usually unexpectedly and unanticipated.

Bond (2004) alerts the researcher to the continued well-being of participants beyond the life of the research activity. Similarly, his specialist seminar at Metanoia emphasises that the research does not take precedence over the well-being of participants. During data collection, I encountered this very experience during the focus group with mental health lecturer-practitioners when one of the participants dominated the discussion with her own experiences of her daughter's death the previous year. In advance of the event, I had distributed copies of the materials for their professional scrutiny and feedback and had also placed a set of four diagrams at places around the table just prior to the meeting. I was, therefore, taken by surprise at the focus of attention and noted how myself and the two other participants accorded her the space to use the meeting to describe her experiences as a bereaved mother. I made only one attempt to refocus (Krueger and Casey, 2009) on the materials and open up dialogue with the group. In a lesser way, I liken this to Bond's (2006) seminar example of having to ethically abandon a piece of research in the better interests of participants. I'm also reminded, yet again, of Carroll's (2005) psychological contract seminar; clearly mine and hers were very different and I did not consider it ethical to voice that the intended focus was scrutiny of the materials in front of them. This would have created a shame dynamic for her which is to be avoided at all costs and which would, in any case, have introduced a negative dynamic into the group (Krueger and Casey, 2009). Paradoxically, it would most likely have caused emotional harm to her; certainly, emotional distress.

I take researcher responsibility for this as I had not deemed it necessary to put on the PI sheet an exclusion criterion about not being recently bereaved in order to participate. Had I done so, however, my sense is that this could have been hurtful to her as my invitation to participate went to all the mental health lecturers. Interestingly, I did not know this individual and learnt in the focus group that she was in the process of gradually phasing back into work. I thought I knew all the MH lecturers and had not sent out individually named email invitations, using instead the faculty email address for the team. I believe this is an example of the pitfalls of conducting research within your own organisation (Coghlan and Brannick, 2005). Interestingly, Richards (2009) challenges the use of the word 'bias', claiming it is (miss)used negatively in research rather than adhering to its literal meaning of cutting the cloth according to bias, for the best fit of the garment. Rather than view the collected data as unyielding of its intended purpose, I cut across the bias to represent the data in its most enlightening and valuable form as first person phenomenological experience.

During the writing up phase, I encountered a further dilemma in respect of data collected of an important emerging phenomenon which I became increasingly uncomfortable writing about. Reflexively processing the possible impact upon readers whose own story might resonate with graphic detail or, the necessary procedures professionals are required to follow in tragic circumstances and how that in turn can impact upon professionals in the immediacy of their work,

forcibly struck me as not being helpful to anyone, least of all bereaved people. During the Final Projects seminar at Metanoia, I consulted the programme leader and my peers about the value and significance of the data and my ambivalence about reporting upon it. The outcome was to locate and only write about the issue within existing literature, rather than adopt a biographical narrative approach and to further discuss with my academic advisor and consultant. In effect, that is how I resolved the dilemma, subsequently omitting any references to specific phenomenon from interview data. As Loewenthal (2007) suggests, I removed all identifying material and did not include specific descriptions of scenarios of the phenomena being described and thereby avoiding an identifiable event.

Equally, ethical issues have been important in the handling of autobiographical and biographical raw data and Bond (2004) reminds psychotherapy researchers to maintain confidentiality and remain respectful to participants beyond the life of the research project.

5.7 Critique of the study

Firstly, a critique of the methodology. A longitudinal study of bereavement training does not exist in literature sources and, given the length of time taken for this project, it would have been appropriate and a better choice: a clear protocol for timely data collection at planned intervals. Likewise, my preference to adopt a Dionysian approach to action research, on reflection, was misplaced: the Apollonian approach promotes a structured research protocol. I believe that I was

attracted to the former because of its acknowledged chaotic characteristic which resonates with the known chaos of bereavement and so thought it would be a good match.

The more phenomenological approach applied to the gathering of data from participants, whilst yielding highly valuable data, resulted in an absence of data on key elements of the training. A specific remit or reference for the action groups would have likely captured greater breadth of enquiry. The sample size for the immersion cycle was small and, again on reflection, it would have been better to have held more immersion cycles of similar small size with the extended action cycles, rather than groups of 12 participants.

In writing this document, I became acutely aware that I have not represented
The bereaved client group for whom the death of someone is a genuine relief and releasing experience and one where the phrase loss and death would be replaced with absence and death to more accurately represent their experience. This particular group appears to be a minority however they should not be discounted from the material and I need to address this.

I am equally aware that my intention to bracket, (epoché) was not always achieved and this is at times evident in respect of the WBS FG4 transcript.

Reflecting on this, I acknowledge that my own enthusiasm and committed energy occasionally emerged and, regretfully, I then dominated dialogue.

5.8 Implications for Practice

The diagrams have been authenticated as pertinent to therapeutic practice and conducive to the training context and are still in use as the core component of a six day training: their currency established.

Similarly, in respect of Wirral CRUSE to whom, on being asked, I gave permission for their trainers to use them with new recruits. Following the death of my colleague for the PAC training, I signed over the materials developed for their trainings to the new training manager.

In addition, I am currently using two of them, the experience of grief (GED1) and of trauma though I have replaced G (T) ED with just TED to be fit for purpose in my new practice context.

Mimetic traumatization has implications for both trainers and trainees. It is my intention to write an article for publication to open the debate on this as a concept

of which to be mindful. Clearly, research needs to be conducted and I am hopeful that colleagues at Nottingham University might be interested in doing so.

A further area for research enquiry concerns psychotic grief in bereavement as clearly practitioners, whether trainees or qualified, have encountered psychotic processes in some clients. The literature specifically on psychotic bereavement is sparse, certainly in comparison to the corpus of work on bereavement. Implications for trainers is likely to be a question of time to spend on this aspect of grief and how to 'demonstrate' psychotherapeutic practice in working with this phenomenon. The training institute feels better equipped to integrate it into their much longer training programmes.

In general, implications for trainers is the provision of visual stimuli and other artefacts to energize and engage trainees in active discussion and storytelling as a means of generating deeper insights and learning. So too the provision of information which stretches beyond knowledge about loss and grief to address the whole experience which may involve encounter with other professionals at the client's most vulnerable time. There is of course a paradox in training on bereavement: you have to make it live, to bring it alive for the trainee.

Chapter 6: Conclusion

My research has not been with bereaved people. A great deal of research has already informed praxis in this domain, based on the already researched experiences of the bereaved. My study has been with those whose professional work brings them into contact with bereaved people and how to convey and disseminate bereavement phenomena to those professionals.

In the literature, I found a consensus of opinion, a convergence of theoretical and clinical belief on the impact of loss and grief… Although semantically there are clear differences amongst leading clinicians and authors, implicitly recognition of bereavement phenomena has universal agreement. The chasm lies in clinical interpretation: whether a bereaved person has or has not a psychological disorder resulting from the manifestation of their grief.

The contribution to psychotherapy and the wider professional field has been identified and currency been established through the transferability of material across other professional contexts, aided by the non-prescriptive nature of its use, whereby participants have integrated what is applicable within their own professional context.

‘Mimetic Traumatisation (MT) has been inductively elicited as a potential risk of exposure to material which mimetically represents traumatic events. This could

have implications for other psychotherapy training courses as well as other professional groups.

Throughout the writing of this document, I have argued for an epistemology of bereavement which I re-iterate as being more pertinent in working with bereaved people. Practitioners can best serve the bereaved by embracing their world and all its complexities and see themselves as researching into, enquiring into the individual's bereaved experience.

In conducting this study, I have learnt much about myself as a researcher, a trainer, a practitioner and a person.

In closing this project, it has a personal Gestalt feel to it: my work context places me in a role with opportunities to make a difference to others' understanding of the impact of phenomena upon themselves and others they encounter. This holds much meaning for me from both a professional and personal perspective and I am grateful to have had this albeit long and arduous journey.

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APPENDICES 1 to 39

APPENDIX 1

A Client Writes…

I am writing this testimonial for Wandsworth Bereavement Service because last year I lost one of my closest frinds. This changed my own and many of my friends lives forever. The counselling I received from xxxx at WBS has allowed me to come to terms with her death and the events surrounding it.

To give a bit of background, when I first came for counselling, last February, I was 29 and I had lost my friend xxxxxxx in the September 11th terrorist attack on the World Trade Centre in New York. She was 330, had everything to live for and was surrounded by friends and family who loved her dearly.

At the time, I felt very alone and isolated and was unable to cope with many of the day to day activities that I had always taken for granted. I had lost my confidence, was having difficulty relating to the people closest to me and got upset about even the smallest things.

Through the counselling I shared with xxxx, I was able to understand how the loss I suffered was impacting on my self confidence and how the emotions I felt were linked to the death of my friend.

We were also able to work through some of the feelings and challenges I would face when I visited New York for the 1st Anniversary Ceremony in September. The sessions allowed me to manage my emotions and ensure that I got the closure I needed from my trip.

I can honestly say that the counselling I received was one of my most positive life experiences, caused by one of my most negative.

A special person was taken from me. Counselling had given me the power and confidence to take my happy memories of our friendship back from withn the traumatic events that surrounded September 11th.

I now remember my friend and enjoy the friendship we shared. Thank you.

A WBS Counsellor Writes About Her Experience…

I saw 'little Johnny' aged two and a half years, for 6 months. A bright little boy with good language skills, fun loving and polite. I took a basket of objects to play with – fingerpaints, crayons, car, ambulance, shell, play people etc. and used the initial sessions to work out the manner of his sister's death. Much crashing of cars and Ma said he thinks she died in a car crash. Gradually he grasped the truth … and showed this using the toys.

He showed some anger half way through with much slamming around with football and running around, prior to his statement that his sister had died and he missed her – said in a quiet unsolicited moment when we were sitting on the floor together.

He never talked of her unless prompted. We developed a game with a cowrie shell: first me "listen to the sea!", then Johnny "pretend Sophie is in the shell". We used this as a method of saying things to Sophie and her replying. He wanted very much to go to the grave. I took Ma, younger brother and little Johnny one session. First he chose some yellow chrysanthemums, then we went to the grave. It was a small grassy plot with a tiny cross one end and a green telly tubby and two plastic windmills at the other. At first he was confused and couldn't understand where Sophie was, why she didn't say goodbye. After wandering around for a while he suddenly plopped the flowers by the cross. Then I left him alone with Ma and went to mind the baby. I think she encouraged him to say goodbye to Sophie. When I returned he asked me where Sophie was. I said under the ground because she wasn't living like him any more but dead so she couldn't talk or play with him. But he could still think about her and remember her (and we talked about it next session). He seemed relieved to have gone and fell into a deep sleep on the way home. Later, he made a good connection. He said that Sophie was not really in the cowrie shell, nor is the Sophie he knew really there; she's in her grave and can't talk to him. After this, Sophie was mentioned less as sessins progressed even when prompted by me, and nursery school staff reported how good, happy and settled he was. Final sessions confirmed my belief that he was ready for the bereavement work to end. – He wanted to play skating in fingerpaint non- stop! Plus, no response to the mention of Sophie. He wanted me to show him how to write a 'J' – (investing in his new life again?) – and again reports from a number of people said he was \cting as a bright, happy, little boy.

The next to last session, I drew a matchstick family. He told me where to place them. His family was definitely:-

Dad, Johnny, Ma, brother A GAP… (a part of the family but set apart), Sophie and a grave with the yellow flowers he had put on. And he asked: "on back of paper please, a telly tubby" – which is on Sophie's grave.

For the last session, he had decided on a picnic. I'd asked if there was anything special he wanted and he had replied: "a table cloth, please". I brought the table cloth, some food for our picnic – a few little sausages, small egg and marmite sandwiches, crisps, tiny iced gem biscuits and cornflake crispies. He wanted water or milk to drink. He helped me set it all out. We spread the table cloth on the floor, put the food on it and set the places. He had invited Ma and his brother and had setout a place for them. He had not set a place for Sophie. Little Johnny handed things round to everyone while I read a board book in the shape of a picnic basket, with story that I had from my own children's time. He enjoyed it. After eating together and the story telling, I asked Ma to leave Johnny and I alone so we could complete our task together. I had decided to tell him a story of "Once upon a time there was a little boy called Johnny…" – a recap on the counselling and events we had covered together. After a while he got bored and somehow lost the cowrie shell that I had offered to him to keep. A good sign, I thought – he's done with it all! And didn't want my 'perfect ending'!! On to the next stage then!

I explained I had come to help him when he felt very sad about Sophie and how he seemed much better and had nice fiends at school and Mummy was feeling better too. So it was time for me to say goodbye. Could he come and see my cats? he said hopefully. I said "No", they were too far away but I'd enjoyed our time together and I hoped he felt happier now. He then left the room to find his Mum – a little sad and so was I.

Before I left, he wanted me to give him some 'stickers'. He had 'a good boy chart' for eating food, weeing in his potty, etc. He chose 3 stickers. I put them on hi s Tee shirt. He then awarded me one! A picture of Roald dahl's 'Big Friendly Giant' holding a small person in his hand. How apt I thought. What a lovely present. I think little Johnny is a survivor and full of joi de vivre. I hope life goes well for him.

APPENDIX 2

Client Narrative, Interpersonal Assessment Form for Bereavement

CLIENT DETAILS:

Client Reference / ID:

Referral Date: Assessment date:

Referred by:

Referrer telephone number:

Client DOB: Age:

How client describes his/ her ethnicity and cultural background:

First Language: Second language:

Religious and cultural beliefs of importance to client:

Client contact details:

Landline number: OK to leave messages: YES/ NO

Mobile number: OK to leave messages: YES/ NO

GP Name:

Address:

Telephone contact:

NATURE OF DEATH/ LOSS:

Loss/ Death Event:

Date occurred:

(Name(s) used by client): Their age at time:

Relationship to client:

Intrapersonal meaning of the relationship to the client:

How the client experienced the loss/ death:

Sudden	☐	**Unexpected**	☐	**Untimely**	☐	**Anticipated**	☐
Violent	☐	**Traumatic**	☐	**Died alone**	☐	**Client present**	☐
Calm	☐	**Geog distance**	☐	**Other losses**	☐	**No. of losses**	☐

Significant details surrounding the cause and circumstances:

(As described by the client in his/ her own words)

Impact of bereavement on the client; at time and in the present:

(As described by the client in his/ her own words)

SUPPORT SYSTEM:

(Establish levels of support/ isolation from different sources)

Family: Siblings/Ages:

Personal relationship:

Children:

Support network (e.g. family, friends, community, religion, work):

Well supported ♦ Limited support ♦ No support ♦

(As experienced by the client)

Isolated in their grief: Slightly isolated ♦ moderately isolated ♦ Very isolated ♦

(As experienced by the client)

PREVIOUS SIGNIFICANT LOSSES:

(As discussed with and identified by the client)

Addressed:

Unaddressed:

OTHER INFORMATION RELEVANT TO THE CLIENT'S EXPERIENCE:

Compounding factors i.e. attachment and personality style, funeral difficulties/ family disputes / secrecy issues/ finance/ ill-health / cultural and acculturation complexity...

RELEVANT EMOTIONAL, PSYCHOLOGICAL, MEDICAL HISTORY:

Any current medication:

(E.g. for heart, diabetes, blood pressure)

Any previous psychiatric, psychological or emotional difficulties:

Essential information - Timescale/Nature of difficulty/Context/People involved…

Current psychological/ emotional states/ behaviours:

Essential information - Nature/Period/Suicide ideation/ Self harm practices…

Health care and other professional involvement:

IAPT ☐	Hospital ☐	CMHT ☐	Key worker ☐
Social Worker ☐	Psychiatrist ☐	CPN ☐	Health Visitor ☐
Housing Officer ☐	Employer ☐	Other:	

Name and designation of health care professionals for liaison (key worker, psychologist ...):

INDICATORS FOR THERAPY:

Client's previous experience of therapeutic intervention:

Observations of Bereavement Assessment:

Chronic ☐	Compounded ☐	Delayed ☐	Multiple loss ☐
Denial ☐	Avoidance ☐	Idealisation ☐	Traumatic X☐
Realistic ☐	Resilient ☐	Resolute ☐	Robust ☐
Panic attacks ☐	Agoraphobia ☐	Claustrophobia ☐	Reclusivity ☐
IBS ☐	Tinnitus ☐	Other:	

Overall assessment statement:

Client's perceived needs/ main focus for therapy at this point in time:

Client's readiness for therapeutic intervention:

Risk category: Low ♦ Moderate ♦ High ♦

(Include relapse of previous conditions e.g. depression)

Additional comments:

Client's capacity to engage in counselling (personal resources ego strength…):

(Is grief therapy in client's best interests at this point in time or is other support more appropriate?)

Any significant cultural / religious issues… for client in client / therapist relationship? : (note preferences and ageist / gender / racist and prejudicial requests are to be explored at assessment to establish basis of significance)

Client's commitment to therapy: Uncertain ♦ certain ♦

Possible boundary issues ♦ barriers ♦

Specify any blurred boundaries or identified barriers to therapy (e.g. Alcohol/drug use…)

ALLOCATION INFORMATION:

If unable to offer client a service, please give reason(s):

Or reasons for recommending/ postponing an allocation:

Client's availability for therapy: Days: Times:

Therapist allocated: Date:

Allocation matters of client/ therapist safety, specific mental health issues, therapist competency to accept allocation: Yes/ No

Discussed with therapist allocated: Yes/ No Date:

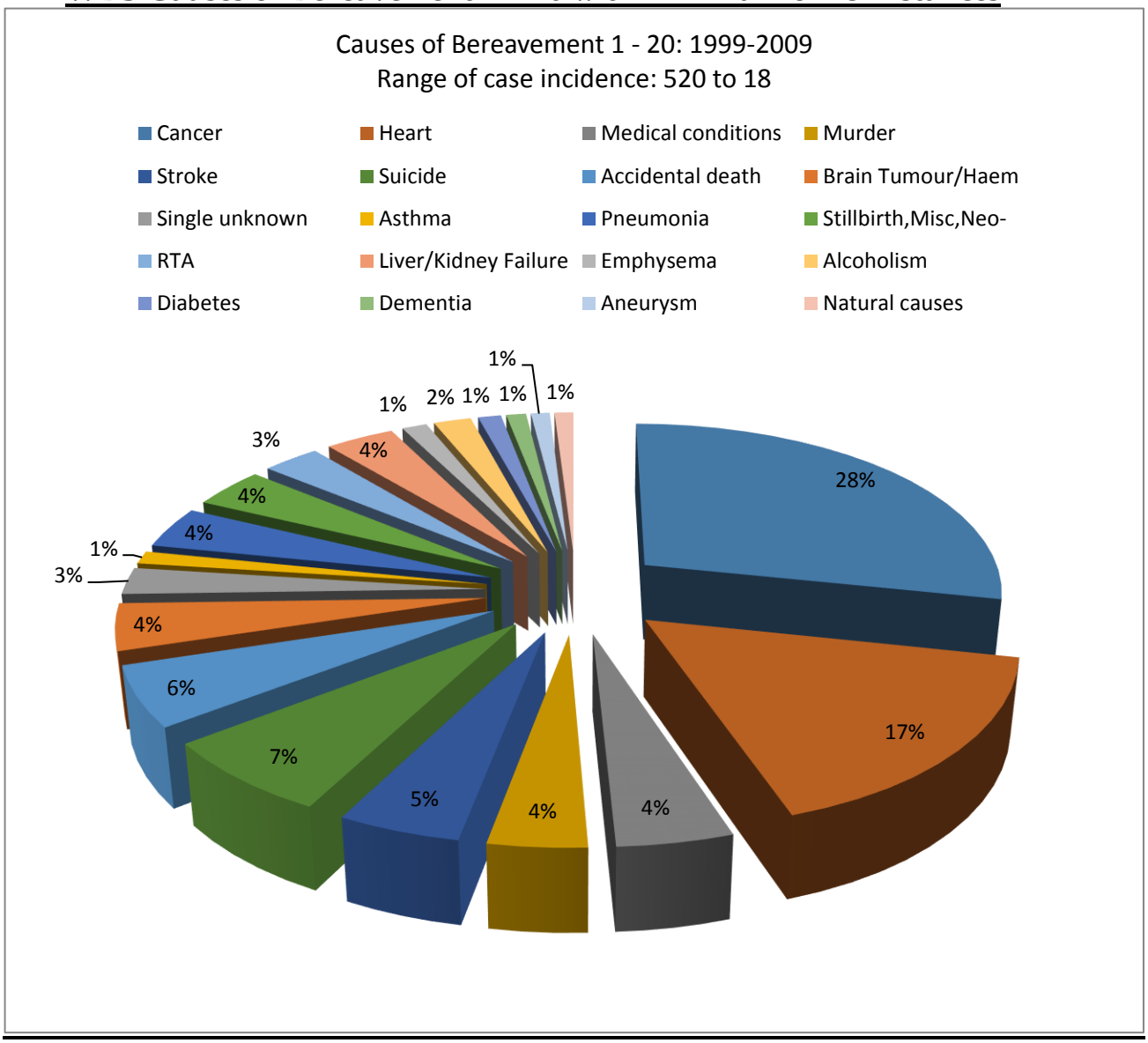
Client confirmed start of therapy: Yes/ No Date:

1st Appointment date: Time:

Details of difficulties encountered in contacting client to make allocation for therapy:

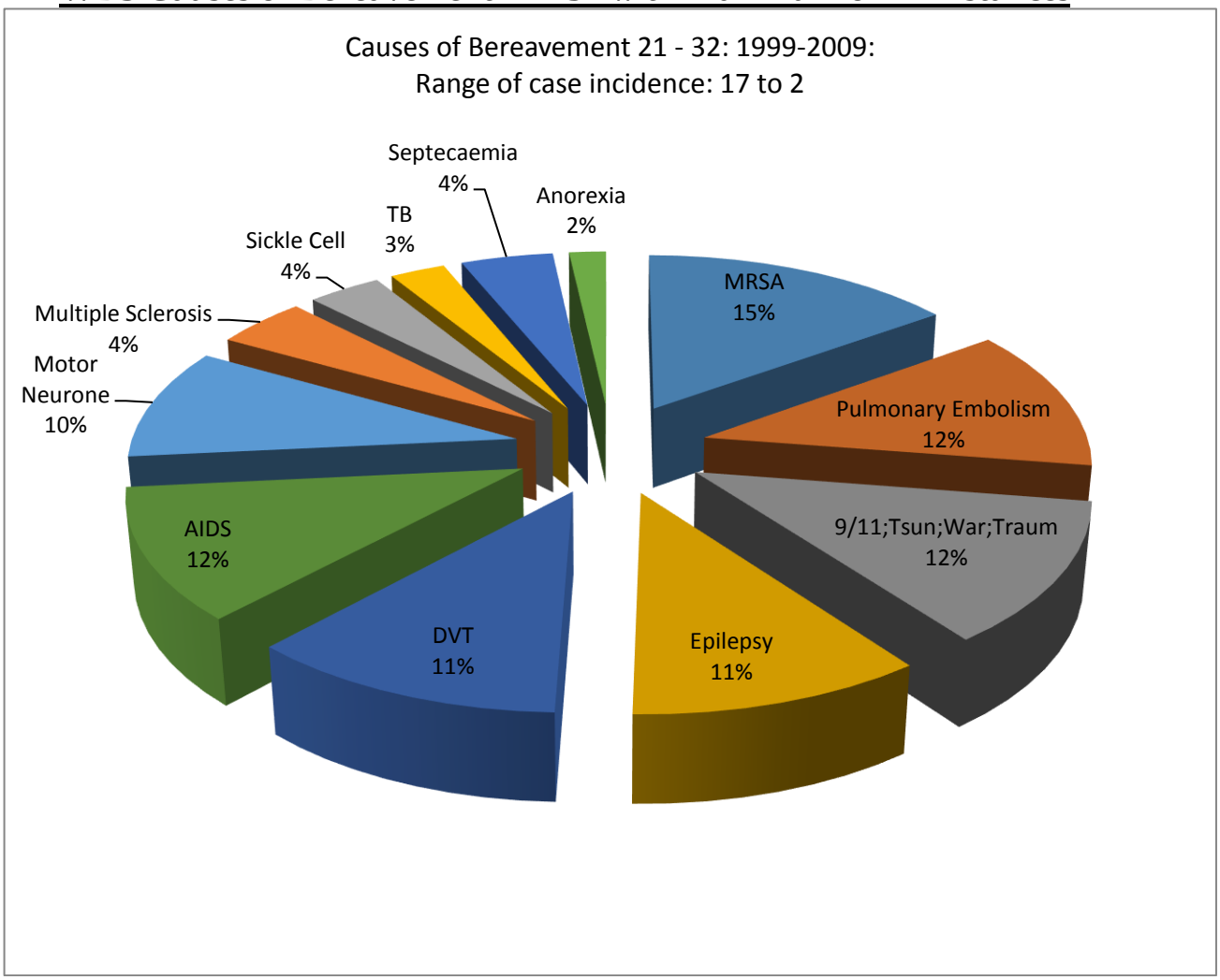
APPENDIX 3

WBS Causes of Bereavement 1 – 20 with Minimum of 18 Instances



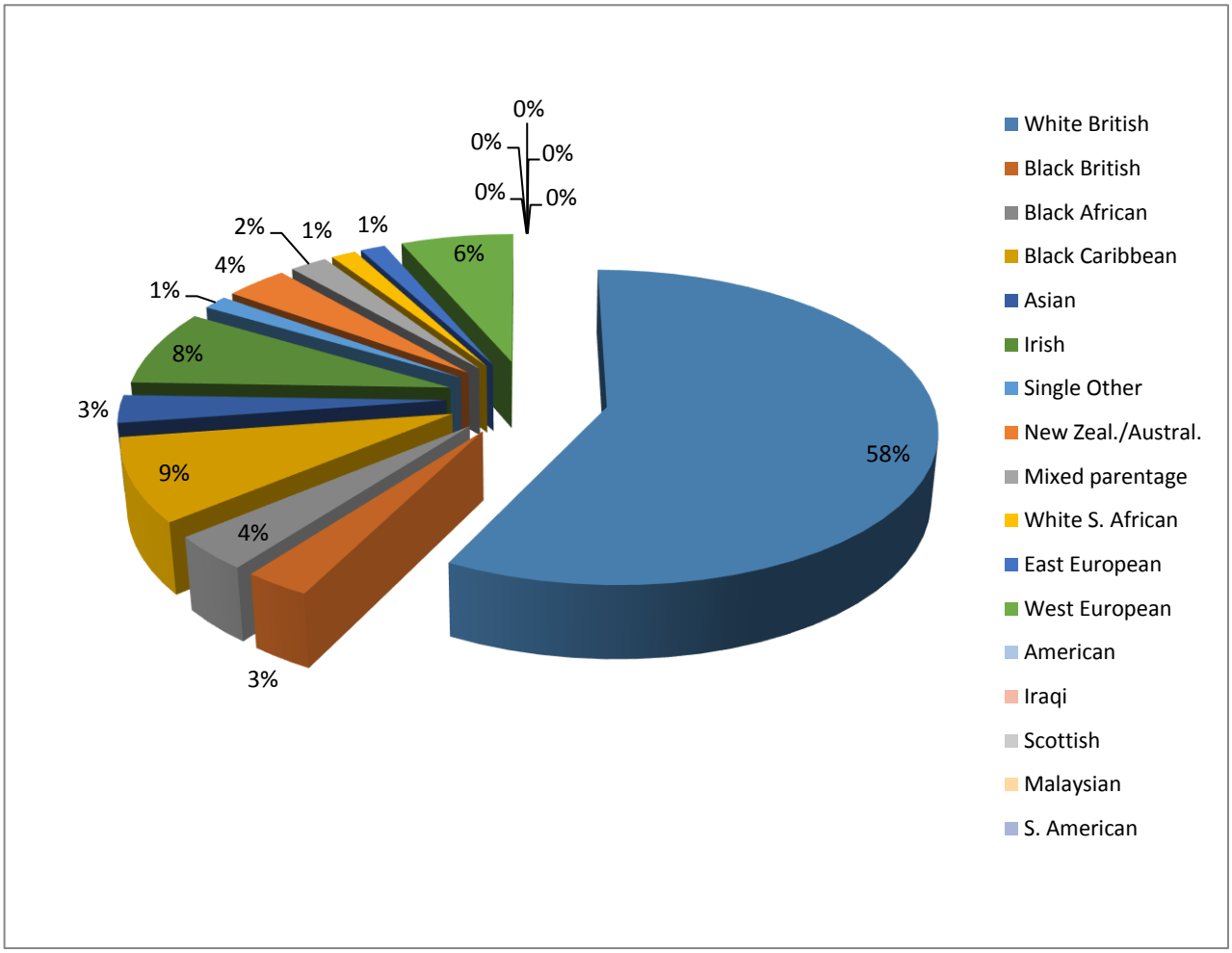
The causes of bereavement are presented as reported by the bereaved person at initial assessment, not as an interpretation of the assessor. Of interest therefore, is the notable fact that liver and kidney failure are reported as the cause of death in 4% of clients whilst diabetes (1%) and alcoholism (2%) are reported much less frequently as the primary cause despite the liver and kidney failure deaths resulting primarily from one of these medical conditions.

WBS Causes of Bereavement 21 - 32 with Maximum of 17 Instances



Of interest here, is the incidence of MRSA reporting which only began in 2002, indicating more public awareness of the incidences of death from hospital infection as opposed to terminal illness or severity of a medical condition. Similarly, WBS experienced instances of bereavement work resulting from world events, which was noted as self referrals occurring at least 6 months following the disaster and usually much later. In instances of traumatic events, it is usual for people to seek professional input some considerable time after the event, including years after (Dedert et al., 2009).

WBS Ethnicity of Client Population:1999 - 2009



Over a ten year period, the numbers of American, Iraqi, Scottish Nationalists, Malaysian and South American accounted for less than 1% of the total client population. However, on an annual basis they do account for one or two individuals. For example in 2001, two American nationals received counselling linked to the 11th September attack on the Twin Towers in New York.

The following *Table* represents the number of clients who have actually been in therapy at WBS following their initial assessment whilst the number of individuals who have been assessed at WBS is in fact considerably higher.

10 Year Audit of Age Range of WBS Clients: 1999 - 2009

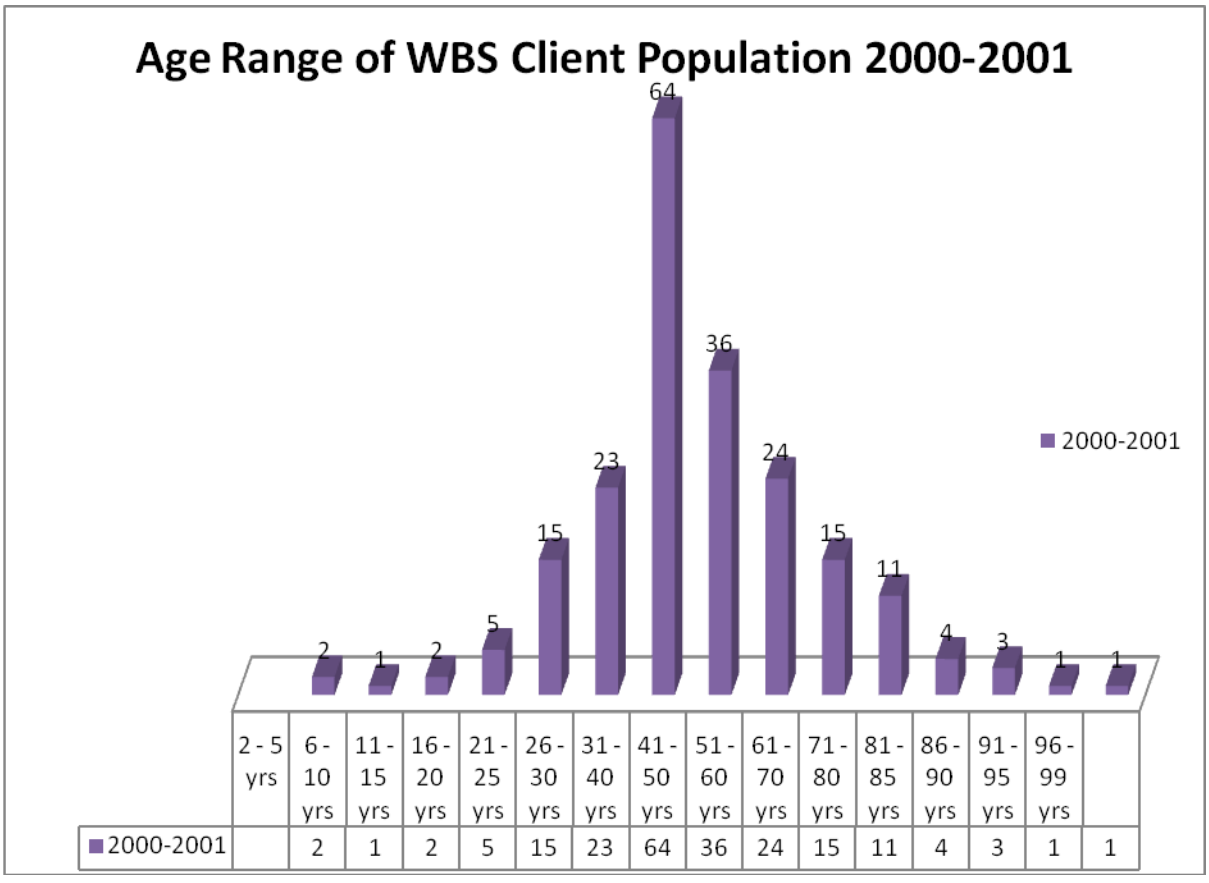
Audit Year / Age Range	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	TOTAL
2 - 5 yrs		2	3	3	2	1	3	1	1	0	**16**
6 - 10 yrs	0	1	3	4	3	1	4	2	2	0	**20**
11 - 15 yrs	0	2	5	5	4	1	6	3	2	4	**32**
16 - 20 yrs	5	5	4	2	6	4	8	5	5	6	**50**
21 - 25 yrs	12	15	11	22	8	6	9	10	8	10	**111**
26 - 30 yrs	17	23	32	28	33	15	21	30	29	32	**260**
31 - 40 yrs	38	64	47	56	55	26	49	55	38	49	**477**
41 - 50 yrs	24	36	33	31	32	20	43	37	42	54	**352**
51 - 60 yrs	24	24	24	22	21	20	20	29	19	20	**223**
61 - 70 yrs	8	15	12	12	14	4	10	10	9	16	**110**
71 - 80 yrs	7	11	11	10	8	7	11	7	6	7	**85**
81 - 85 yrs	2	4	2	1	1	1	2	3	2	3	**21**
86 - 90 yrs	2	3	1	0	1	1	1	3	1	1	**14**
91 - 95 yrs	0	1	1	0	0	0	1	0	1	0	**4**
96 - 99 yrs	0	1	0	0	0	0	0	0	0	1	**2**
TOTAL	**139**	**207**	**189**	**196**	**188**	**107**	**188**	**195**	**165**	**203**	**1777**

Notably, in the 2001 audit year, the youngest clients were aged 2 years and the eldest 99 years of age.

Represented in Figures 4 and 5 below is the age range demonstrated by the normal distribution or ’bell’ curve associated with social science research (Sanders and Wilkins, 2010). This is significant in WBS history evidencing its evolutionary shift from bereavement work with the elderly to meet the needs of all bereaved age groups. In August 1996 when I first took up post at WBS, the majority of the

client work was focused on the elderly, with home visits being the norm. By May 1998, I had relocated the service to premises better suited to therapeutic work and brought all counselling activity into the premises and established a service level agreement with the local Health Authority. These changes enabled WBS to broaden its remit and develop its work in the bereavement field. Notably, in the 2000-2001 audit year, the youngest client was aged 2 years and the eldest 99 years of age.

Distribution of Age Range of WBS Clients in Audit Year 2001



Normal Distribution Curve of Age Range of WBS Clients:1999 – 2009

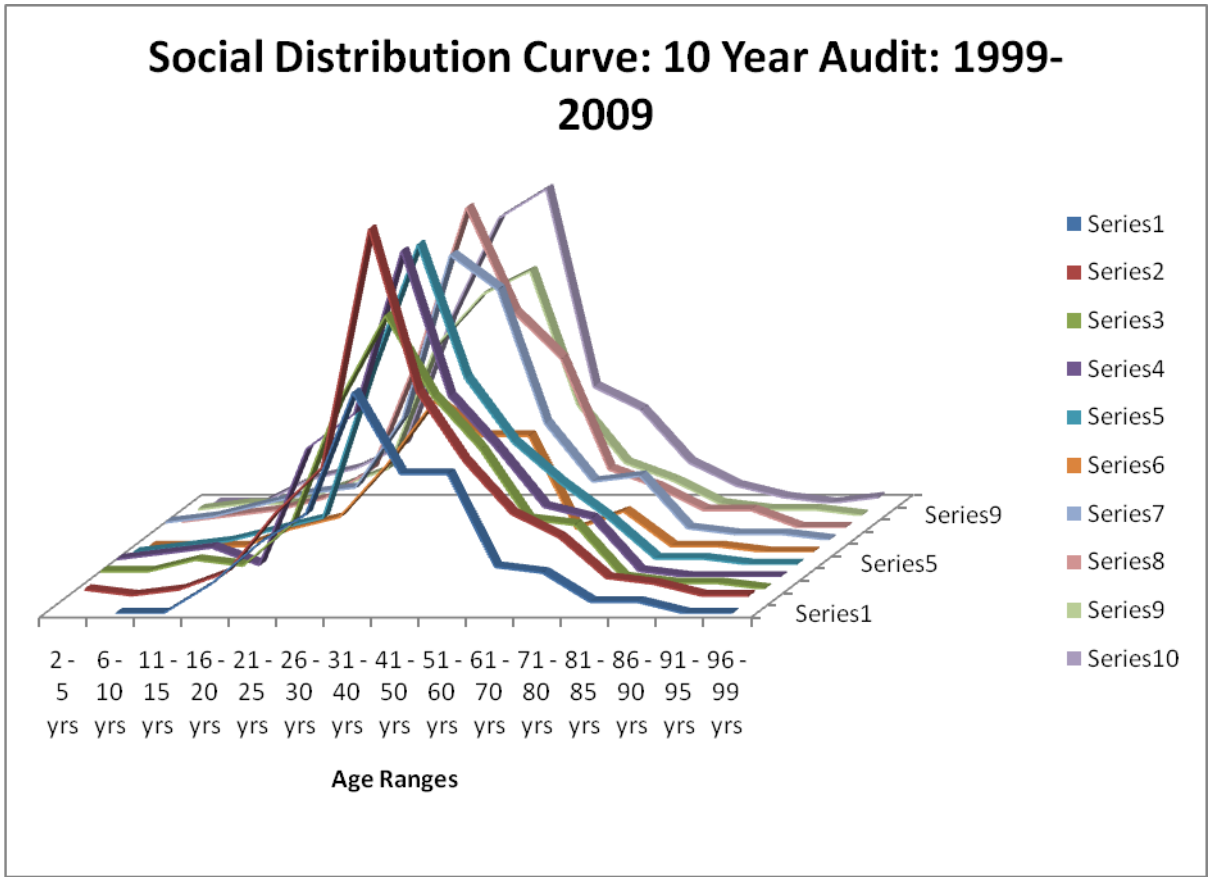


Figure 5

Although 2001 marked the widest range in ages, an increase in the younger aged client group began in early 1998. I believe the significant increase in the younger, working age population was due to an event in 1997 that shocked the world princess Diana's death. There had been a major cultural shift in the UK about being bereaved and showing personal distress over loss. A shift from the stoic, British attitude to death and grief, to an acknowledgement and acceptance of expressed sorrow across the far wider population in London. It was as though it had become respectable to grieve.

The increase in the younger aged population presenting for bereavement counselling, became synonymous with a rising prevalence in job losses. Many of the younger clientele were city professionals: men and women working in finance, in banking and stock market trading and solicitors in legal firms. These professionals were under great pressure to maintain their former levels of

performance, irrespective of their bereavement, particularly in the financial sector. Within this latter group, where former performance levels had not been re-established, some clients had their contracts terminated. Always at least 3 months after the bereavement, thus allowing the commissioning employers to terminate on the grounds of poor performance alone. In this way, employers could avoid individual personal circumstances which might require a more compassionate approach, and one less conducive to performance targets and outcomes. Other non -professionals similarly and equally faced job losses; for example those in retail and the building. Employers did not find it difficult to replace staff. It seemed the vulnerable bereaved were expendable for having normal manifestations of grief. Such known information contributed to both the content of the assessment form and the training programme as well as the emergence of psycho-education materials.

APPENDIX 4

PHQ-9

Over the past two weeks how often have you been bothered by any of the following problems

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

Total PHQ-9 Score ☐

If you selected off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐ No response ☐

APPENDIX 5

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use “ ” to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Scores of 5, 10, and 15 represent cut points for mild, moderate, and severe anxiety, respectively.

APPENDIX 6

ANXIETY AND DEPRESSION SCALE (HAD)

This questionnaire is designed to help your Counsellor know how you feel. Read each item and place a firm tick in the box opposite the reply that comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick only one box in each section

I feel tense or wound up: 3 Most of the time □ 2 A lot of the time □ 1 Time to time □ 0 Not at all □	**I feel as if I am slowed down:** 3 Nearly all of the time □ 2 Very often □ 1 Sometimes □ 0 Not at all □
I enjoy the things I used to enjoy: 0 Definitely as much □ 1 Not quite so much □ 2 Only a little □ 3 Hardly at all □	**I get a sort of frightened feeling like butterflies in the stomach:** 0 Not at all □ 1 Occasionally □ 2 Quite often □ 3 Very often □
I get a sort of frightened feeling as if something awful is about to happen: 3 Very definitely and quite badly □ 2 Yes, but not too badly □ 1 A little, but it doesn't worry me □ 0 Not at all □	**I have lost interest in my appearance:** 3 Definitely □ 2 I don't care as much as I should □ 1 I may not take quite as much care □ 0 I take care just as much as ever □
I can laugh and see the funny side of things: 0 As much as I always could □ 1 Not quite as much now □ 2 Definitely not so much now □ 3 Not at all □	**I feel restless as if I have to be on the move:** 3 Very much indeed □ 2 Quite a lot □ 1 Not very much □ 0 Not at all □
Worrying thoughts go through my mind: 3 A great deal of the time □ 2 A lot of the time □ 1 From time to time but not too often □ 0 Only occasionally □	**I look forward with enjoyment to things:** 0 As much as I ever did □ 1 Rather less than I used to □ 2 Definitely less than I used □ 3 Hardly at all □
I feel cheerful: 3 Not at all □ 2 Not often □ 1 Sometimes □ 0 Most of the time □	**I get sudden feelings of panic:** 3 Very often indeed □ 2 Quite often □ 1 Not very often □ 0 Not at all □

I can sit and feel relaxed:		**I can enjoy a good book or radio or TV programme:**	
0 Definitely	□	0 Often	□
1 Usually	□	1 Sometimes	□
2 Not often	□	2 Not often	□
3 Not at all	□	3 Very seldom	□

Anxiety score	
Depression Score	

APPENDIX 7

Prolonged Grief Disorder: A New Diagnosis

Proposed for new editions of DSM -V and ICD-11 due for publication in May 2013.

'Prolonged Grief Disorder: Psychometric Validation of Criteria proposed for DSM-V and ICD-11'.

Authors: Holly Prigerson, Mardi Horowitz, Selby Jacobs, Colin Parkes, Mihaela Asian, Karl Goodkin, Beverley Raphael, Samuel Marwit, Camille Wortman, Robert Neimeyer, George Bonanno, Susan Block, David Kissane, Paul Boelen, Andreas Maercker, Brett Litz, Jeffrey Johnson, Michael First, Paul Maciejewski.

Criteria for a distinct mental disorder and diagnosis of PGD:

Criteria requirements: 'reactions to a significant loss that involve the experience of yearning'. For purposes of their study, yearning was identified as 'physical or emotional suffering as a result of the desired, but unfulfilled, reunion with the deceased' ((2009: 1-2).

For diagnosis, a bereaved person must meet the 'yearning' criterion and a minimum of five out of nine other criteria (symptoms) experienced on a daily basis or to a disabling degree OR, experience life as meaningless.

- Feeling emotionally numb,
- Stunned or,
- that life is meaningless
- Experiencing mistrust
- Bitterness over the loss
- Difficulty accepting the loss
- Identity confusion
- Avoidance of the reality of the loss
- Difficulty moving on with life

The symptoms must be present for at least six months from the death (or loss) alongside evidence of functional impairment.

Reference: Prigerson et al (2009) PLoS Med. 2009 August; 6 (8): e1000121; 1 – 15. On-line DOI ref: 10.1371/journal.pmed/1000121.

APPENDIX 8

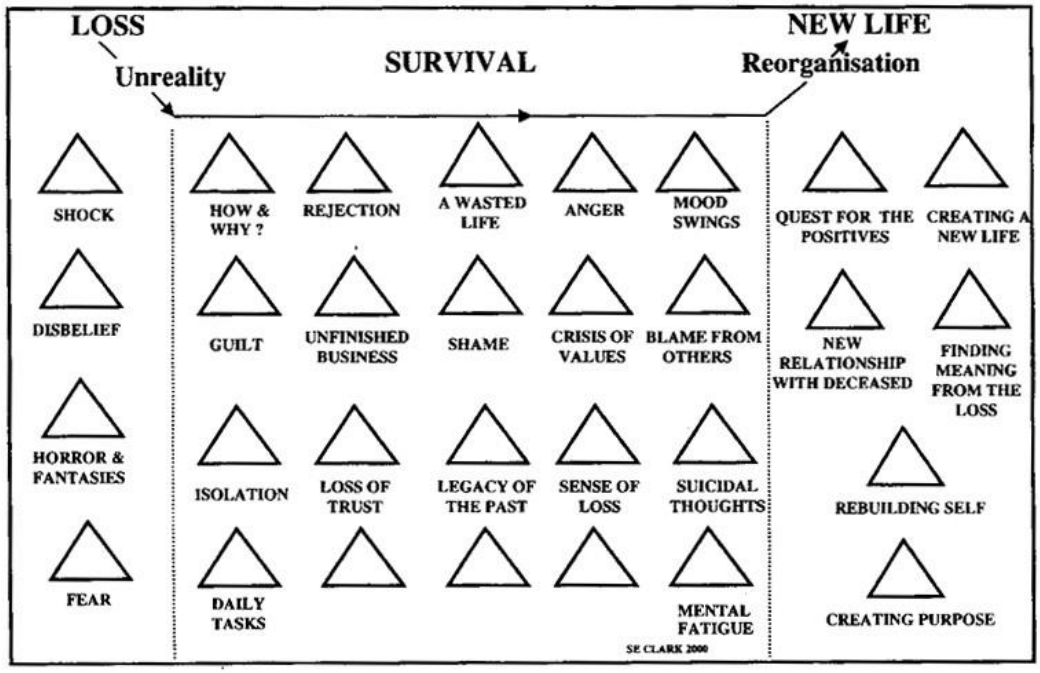
Worden's 2010 Revised
4 Tasks of Mourning

	Opposite being:
1. To accept the reality of the loss	(Not believing)
2. To process the pain of grief	(Not feeling)
3. To adjust to a world without the deceased	
A. External adjustments: Living daily without the person	(Not adjusting)
B. Internal adjustment: Who am I now?	(Not growing)
C. Spiritual adjustments:	(Not understanding)
4. To find an enduring connection with the deceased while embarking on a new life.	(Not moving forward)

Reference: Worden, W. J. (2010) *Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner, 4th Edition.* Hove: Routledge

APPENDIX 9

The Grief Map (Clark, 2001)



The map was created using a stepwise clinical and consultative process. The initial draft was the result of a study of grief, using field methodology (Schatzmann & Strauss,1973) in individuals attending a support group for persons bereaved through suicide.

Grief phenomena experienced byparticipants were observed and recorded by the author immediately after each meeting.... Phenomena were drawn as triangles to represent mountains, which were placed under the most relevant sections of a three-part timeline, representing early, middle, and late periods of grieving.

Reference: Clark, S. (2001) mapping Grief: An Active Approach to Grief Resolution. *Death Studies* 25: 531-548.

APPENDIX 10

Teaching learning and Quality Matrix Design

TLQ MATRIX	INFORMATIVE LEARNING	GENERATIVE LEARNING	POIGNANT LEARNING	EXPERIENTIAL LEARNING
PRACTICAL KNOWING: End Product = how to; practice competency: inter professional, psycho-socio-political, legal/ ethical, theoretical acuity				
PROPOSITIONAL KNOWING: Intellectual knowing of ideas and theories. Product= informative spoken or written word				
PRESENTATIONAL KNOWING: Emerges from Experiential Product=significance revealed from expressive imagery: music, sound, drama, poetry, drawing....				
EXPERIENTIAL KNOWING: Immediacy of perceiving; empathy and resonance. Present with person, place, thing. Product= quality of being in the relationship.				

Reference: © Smith, A. (2010): Doctorate in Psychotherapy Study. Adapted from Heron & Reason (2008) Extending Epistemology within a Co-operative Inquiry. In, P. Reason, H. Bradbury (eds.) *The Sage Handbook of Action Research: Participative Inquiry and Practice.* Thousand Oaks, CA; London: Sage 366 – 380. Mapped against research generated 4 Ways of Learning as a Professional Self-Assessment Tool.

WBS PARTICIPANT INFORMATION SHEET

Introduction

Thank you for taking the time to read this information about my research project 'Minimising Psychological Harm to Bereaved People: An Andragogic Psychotherapeutic Endeavour' by Anne Smith.

Rationale for Study

Having specialised for many years in working with a range of bereavement experiences, I realised that despite a lot of diverse professional trainings, information and literature being available on the subject of loss, grief and bereavement, the experience of many bereaved individuals was one of **not** having their emotional and psychological needs met.

The study in brief

As a therapist, supervisor and trainer, I therefore decided to undertake a Doctorate in Psychotherapy by Professional Studies to investigate this phenomenon from the perspective of a practitioner-researcher with particular emphasis upon the professional training dimension of practice. Ethical approval for the research study has been granted by the Metanoia Institute and Middlesex University, the awarding body for the doctorate degree.

Participants

Your participation in this research as someone who is currently or has undergone a professional training in the field of counselling, psychotherapy or counselling psychology, would greatly contribute to its significance and the research outcomes.

You are being invited to participate because you are, or will be actively engaged in working therapeutically with bereaved people. You are also being or have been professionally trained in a particular therapeutic modality and in addition have completed a brief, 6 day intensive training in bereavement and grief work with me, prior to being allocated a bereaved client case load.

Your own experience of the intensive bereavement training and how this did or did not prepare you for the therapeutic work is a key focus of the research. This includes identifying gaps in the training as well as contributing to feedback on the training approach and the training materials in order to revise and progressively enhance them.

What will be your involvement and commitment?

If you agree to participate, you will be involved in a Focus Group interview of an hour which will be audio taped. For your convenience, the venue will be at WBS in the training room which is familiar to you. During the interview, you will be invited to contribute your transparent feedback on the training received, (delivery and materials used), how you experienced the training and how the training did and did not meet your needs/requirements as a therapist working with a bereaved client group.

Are there any risks or hazards to you in participating in this research?

There are no risks or hazards either directly built into the study design or indirectly. In the event that you would like to talk through some aspects of your research involvement following your participation, this will be arranged on a 1:1 basis, at WBS, at your convenience.

What do you have to gain by participating?

As a (student) practitioner within the field, I hope your participation in a study using action research would offer you a level of professional satisfaction in having the opportunity to enhance the research outcomes from your own experience and knowledge gained from practice. Action research is a method which honours and respects the contributions of others, rather than supporting that of the researcher. This study is designed as a co-operative piece of research which will reflect your contributions as a co-researcher. A key end product will be a training manual for distribution and publication, materials to which you will have contributed.

Thank you for considering whether or not to take part in this study.

Anne Smith MA, PGDip. B.Ed.(Hons)
MBACP Accredited Psychotherapist
MBACP Accredited Supervisor
UKRC Registered Practitioner

Doctoral Candidate:
Middlesex Univ./ Metanoia Institute
Email: A.Smith@ljmu.ac.uk
Mobile: 07944-808978

PARTICIPANT RELEASE AGREEMENT: EMAIL

I agree to participate in the research study 'Minimising Psychological Harm to Bereaved People: An Andragogic Psychotherapeutic Endeavour' by Anne Smith.

I understand that in completing and returning the accompanying questionnaire to Anne Smith that I am giving my consent for her to use my responses as data for her research.

I understand that Anne will enter my written responses as anonymised data into a computerised database collection of all participant responses for analysis and will then shred my own original response.

I grant permission for the computerised data to be used in the process of completing a doctoral study and degree, including the writing and submission of a thesis and any subsequent future publications.

I understand the purpose and nature of the study and that my involvement is voluntary and I can withdraw at any time and stage of the research, without prejudice. Also, that I can ask for more information about the study at any time.

I am aware that Anne's DPsych supervisor's are: Prof Pam James PhD, John Moores University, Dept of Psychology, Henry Cotton Building, Liverpool and Dr Nigel Copsey DPsych, The Metanoia Institute/ Middlesex University, 13 North Common Road, Ealing, London. If I have any concerns about this research project, I have the right to contact either or both supervisors to discuss them. Pam James email: p.james@ljmu.ac.uk and n.copsey@btopenworld.com

Signatures:

Research Participant	Researcher
Date	Date

PARTICIPANT RELEASE AGREEMENT

I agree to participate in the research study 'Minimising Psychological Harm to Bereaved People: An Andragogic Psychotherapeutic Endeavour' by Anne Smith.

I agree to a taped meeting of one hour which Anne will then transcribe in preparation for data collection.

I understand that Anne will enter sections from my transcript as anonymised text into a computerised database collection of participant responses for analysis and will then erase the digital recording of the meeting.

I grant permission for the computerised data to be used in the process of completing a doctoral study and degree, including the writing and submission of a thesis and any subsequent future publications.

I understand the purpose and nature of the study and that my involvement is voluntary and I can withdraw at any time and stage of the research process, without prejudice. Also, that I can ask for more information about the study at any time.

I am aware that Anne's DPsych supervisor's are: Prof Pam James PhD, John Moores University, Dept of Psychology, Henry Cotton Building, Liverpool and Dr Nigel Copsey DPsych, The Metanoia Institute/ Middlesex University, 13 North Common Road, Ealing, London. If I have any concerns about this research project, I have the right to contact either or both supervisors to discuss them. Pam James email: p.james@ljmu.ac.uk and n.copsey@btopenworld.com

Signatures to be competed at the meeting:

Signatures:

Research Participant	Researcher
Date	Date

'LUMINARY' PARTICIPANT INFORMATION SHEET

Introduction

Thank you for taking the time to read this information about my research project 'Minimising Psychological Harm to Bereaved People: An Andragogic Psychotherapeutic Endeavour' by Anne Smith.

Rationale for Study

Having specialised for many years in working with a range of bereavement experiences, I realised that despite a lot of diverse professional trainings, information and literature being available on the subject of loss, grief and bereavement, the experience of many bereaved individuals was one of **not** having their emotional and psychological needs met.

The study in brief

As a therapist, supervisor and trainer, I therefore decided to undertake a Doctorate in Psychotherapy by Professional Studies to investigate this phenomenon from the perspective of a practitioner-researcher with particular emphasis upon the professional training dimension of practice. Ethical approval for the research study has been granted by the Metanoia Institute and Middlesex University, the awarding body for the doctorate degree.

Participants as 'luminaries' to the research project

Your own professional knowledge and experience will contribute to and enhance the training focus and emerging training materials to be disseminated in the wider field of counselling and psychotherapy and across multiple and inter-professional fields where bereavement and death are encountered as part of the professional role.

What will be your involvement and commitment?

If you agree to participate, we will meet for a period of an hour when I will outline my interest in your particular expertise in relation to my research project. I will then invite you to respond with reference to your knowledge and experience in your professional role. If you agree, our dialogue will be audio taped and subsequently transcribed.

Are there any risks or hazards to you in participating in this research?

There are no risks or hazards either directly built into the study design or indirectly. In the event that you would like to talk through some aspects of your research involvement following your participation, this will be arranged on a 1:1 basis at your convenience.

What do you have to gain by participating?

I hope your participation in a study using action research would offer you a level of professional satisfaction in having the opportunity to enhance the research outcomes from your own experience and knowledge. Action research is a method which honours, values and respects the contributions of others, rather than being an alliance with and having allegiance to the principal researcher. This study is designed as a co-operative piece of research which will reflect your contributions as a co-researcher. Key end products will be professional training courses, university modules, a university post graduate certificate programme and a training manual for distribution and publication, materials to which you will have contributed.

Thank you for considering whether or not to take part in this study.

Anne Smith MA, PGDip., B.Ed.(Hons)
MBACP Accredited Psychotherapist
MBACP Accredited Supervisor
UKRC Registered Practitioner

Doctoral Candidate:
Middlesex Univ./ Metanoia Institute
Email: A.Smith@ljmu.ac.uk
Mobile: 07944-808978

FIELD SPECIALISTS PARTICIPANT INFORMATION SHEET

Introduction

Thank you for taking the time to read this information about my research project 'Minimising Psychological Harm to Bereaved People: An Andragogic Psychotherapeutic Endeavour' by Anne Smith.

Rationale for Study

Having specialised for many years in working with a range of bereavement experiences, I realised that despite a lot of diverse professional trainings, information and literature being available on the subject of loss, grief and bereavement, the experience of many bereaved individuals was one of **not** having their emotional and psychological needs met.

The study in brief

As a therapist, supervisor and trainer, I therefore decided to undertake a Doctorate in Psychotherapy by Professional Studies to investigate this phenomenon from the perspective of a practitioner-researcher with particular emphasis upon the professional training dimension of practice. Ethical approval for the research study has been granted by the Metanoia Institute and Middlesex University, the awarding body for the doctorate degree.

Participants as 'field specialists' to the research project

Your participation in this research as a mental health practitioner/ lecturer of considerable experience and expertise would greatly contribute to the research outcomes and its validity.

You are being invited to participate because you have a professional mental health training, professional knowledge and experience of emotional and psychological distress.
Your own professional knowledge and clinical experience will contribute to and enhance the training focus and emerging training materials to be disseminated in the wider field of counselling and psychotherapy and across multiple and inter-professional fields where bereavement and death are encountered as part of the professional role.

What will be your involvement and commitment?

If you agree to participate, you will be part of a focus group for a period of one hour during which I will invite you to critically appraise a set of diagrams designed as training materials for dissemination. The focus group dialogue will be audio taped and subsequently transcribed. I will distribute the 5 diagrams in advance of the group meeting.

Are there any risks or hazards to you in participating in this research?

There are no risks or hazards either directly built into the study design or indirectly. In the event that you would like to talk through some aspects of your research involvement following your participation, this will be arranged on a 1:1 basis at your convenience.

Clinical supervision is a professional requirement in our field. As the researcher, I understand that as a result of participating, you have the right and may wish to take specific aspects or issues for discussion to your supervisor whether this be out of a developing interest, unease about any content that arises from our meeting, or to engage in clinical debate and critique about the research topic.

What do you have to gain by participating?

As a practitioner within the field, I hope your participation in a study using co-operative action research would offer you a level of professional satisfaction in having the opportunity to enhance the research outcomes from your own experience and knowledge gained from practice. Action research is a method which honours, values and respects the contributions of others, rather than being an alliance with and having allegiance to the principal researcher. This study is designed as a co-operative piece of research which will reflect your contributions as a co-researcher.

Key end products will be research informed teaching materials available for use on training courses, university modules, an already validated LJMU post graduate certificate programme and a training manual for distribution and publication. As a co-researcher, you will have the right to copy and use any of the materials which you think could be relevant to your own clinical practice and teaching programmes.

Thank you for considering whether or not to take part in this study.

Anne Smith MA, PGDip., B.Ed.(Hons)
MBACP Accredited Psychotherapist
MBACP Accredited Supervisor
UKRC Registered Practitioner

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APPENDIX 15

Teaching, Learning & Quality Matrix

Extended Epistemology of 4 Ways of Knowing Mapped Against Research Generated 4 Ways of Learning

TLQ MATRIX:	INFORMATIVE LEARNING	GENERATIVE LEARNING	EXPERIENTIAL LEARNING	POIGNANT LEARNING
PRACTICAL KNOWING: How to do something. Product = a skill,competence supported by a community of practice: interpersonal, political, technical, manual.	Legal Registry: Birth & Death Hospital funerals; role of H. B'ment Officer and Coroner: inquest inquiry/ projected photos in court; travel license for body or ashes. Police term of RT **Collision.**	Being exposed to other theoretical orientations – including at break and lunch times – and different training practices. Other practices in: NHS services, Organisations.	GED1: Recognising the feeling of 'going back to square 1' when grieving; making sense of this/ gaining positive meaning; knowing client's report of experience is not a relapse in therapy.	A woman still has to deliver a stillborn baby. Only next of kin can register a death; not a life partner. The bereaved are shown CCTV footage of events leading to a suicide death.
PROPOSITIONAL KNOWING: Intellectual knowing of ideas and theories. Product = informative spoken or written word. *(Explicit knowledge.)*	Metaphors: 'Ruche'; 'Ming vase'; Everest. Theoretical concepts: e.g. Idealisation / secondary gains/ **not** about 'letting go' / GED 1, 2, 3, 5; handouts.	Other trainee's cultural roots, values, norms, experiences, including grief and burial rituals. Balinese babies, Hindu babies, Nigerian child, Greek, Jewish, Humanist funeral.	Assessment form and case studies: sudden accidental, (long term) illness, suicide, murder, traumatic b'ment, multiple / compounded loss; gay, lesbian, Hindu, Muslim, Caribbean, African, Asian.	Audio-visual material: authentic footage of clients' loss and grief experiences. Circumstances of death: 'normal' death can be traumatic & comparative trauma vignettes.
EXPERIENTIAL KNOWING: Immediacy of perceiving; empathy and resonance. Present with person, place,	Technological issues in contemporary grieving: email address/ mobile camera phone/ voicemail messages; trainees relate to	Shared losses experienced by group members, including physiological responses, to grief from: death (eg suicide, illness), broken relationship,	Dyad exercises in personal loss and grief exploration. Debriefing exercises and group discussion: examining own reactions to real client	U-tube attachment video. Understanding own responses to past life trauma- related experiences. Tinnitus sufferers known to

APPENDIX 16

WBS Training Questionnaire

This questionnaire is about loss and grief training for bereavement work as a counsellor/ psychotherapist/ counselling psychologist. Please feel free to give critical feedback based upon your actual experience of therapy work with bereaved people following your 6-day training at WBS. Similar responses to questions are not a problem.

1. **What gaps did you find between the training you received and the psychotherapeutic input required to meet the needs of your clients?**
   I did not become aware of a gap.

2. **Is there anything you would change or add to the assessment form (please say why)?**
   I believe that it is a good initial assessment which, however, should be left open and to continually be further informed by the therapist as he/she gets a better sense of the client and his/her very special needs.

3. **What aspects of the training did you find**
   a) of particular theoretical significance in underpinning your therapy work

   -stages of the grieving process

   -attachment theory

   And –information around trauma in general.

b) **most helpful in practice, in sessions with clients**
-The diagrams which made the stages of grief easier to be understood by clients when they were presented as an aid to them.
-and the counselling info regarding the counselling in relation to the tasks of grieving which provided an map of the things that need to be addressed by the therapists.

4 **From the material used in the training, was anything especially poignant which gave you insight into a bereaved person's experience of loss and grief?**
The self-reflective exercises helped me. They unconsciously disabled my rationalization and my detachment and enabled me to really relate to the EXPERIENCE of coming to terms with a loss. Being more open with my own feelings enabled me to be more open to the rest of the material presented as well as to the feelings of others.

5 **What did you like about the training?**
I liked that there was a combination of information regarding both the physiological and the psychological processes following a loss. This information was nicely

processed through practical aspects such as case studies and reflective exercises. Attention was placed not merely on the psychological processes of a client but on our own experiences of loss and all the things that we have learnt experientially through them.

Also, i liked that 'loss' was viewed in a wider context –trauma- and not just the loss of a loved one.

6 What did you dislike about the training?

I did not like the fact that there were no follow ups after the completion of the training. I believe that some follow ups after our increase in clinical practice would have enabled us to process the information in a deeper level; and also, to add to it.

Also, a longer and more complete bibliography could have been suggested at the end of the training.

7 What more would you recommend to be included in the initial training?

a)Although, there was some reference to the attachment theory and attachment styles, i believe that more attention should be placed on that given that attachment issues are the first to be activated following a loss (no matter what type of loss that is). A better understanding of attachment styles and their characteristics could facilitate therapeutic practice as it would enable us to make better sense of the client but also of ourselves and our own attachment styles and the way we react to clients.

b)Role plays could be helpful although i understand that a more extended training would be required to fit in everything.

c)I believe that more attention should be paid to issues of self-care. Supporting bereaved individuals can be very draining. I believe that all therapists should learn to look after themselves better; knowing our limits, especially during times of personal bereavements and other losses. Supervision and personal therapy could be two ways to self-care and at the same time ensure good clinical practice.

8 What do you still use from the training to inform your practice?

It was an excellent training which has formed my whole clinical practice. It has enabled me to view every issue from the view point of loss and its grief; an approach that normalizes all kind of difficulties –both for me and the clients-, especially the working through of the trauma of any type of abuse.

The diagrams that were presented are still five years later, very clear in my head, and regularly used to explain things to clients.

The experiential nature of the training enabled me to value the importance of experiential learning which hopefully makes me a more effective teacher in various training programs.

9 What would you exclude from the training?

I would possibly exclude or just mention very briefly the PTSD information. I think that is only one possible effect of loss which is easier to read about and understand than the processes of: grief, complicated grief, trauma, other losses and how they can be activated through bereavement eg. Abuse, etc.

10 What advice would you give to a peer who is about to start the 6-day training?

I would advice him/her to just be open enough to Experience and take in all the very valuable aspects of the training which will certainly affect his/her whole practice latter on.

Ellen: 5 years after WBS training/ PhD Counselling psychologist; University Lecturer in Greece

APPENDIX 17

WBS Training Questionnaire

This questionnaire is about loss and grief training for bereavement work as a counsellor/ psychotherapist/ counselling psychologist. Please feel free to give critical feedback based upon your actual experience of therapy work with bereaved people following your 6-day training at WBS. Similar responses to questions are not a problem.

4. **What gaps did you find between the training you received and the psychotherapeutic input required to meet the needs of your clients?**

My WBS training took place 3 years ago so I may not remember everything in detail in order to give in-depth answers. While there is an excellent introduction to bereavement work, there are other themes in client work that relate to attachment and loss, identity issues, life span concerns, family dynamics. It may be appropriate to include this in a way to raise trainees' awareness.

5. **Is there anything you would change or add to the assessment form (please say why)?**

Section on family history: past-present relationship w/parents-it tells us about client's personality and relational style-useful info. Also, relationship into current and past- again to assess client's relational style. Alcohol and drug intake- often missed out in assessment and can be important. More details on readiness for therapy.

6. **What aspects of the training did you find a) of particular theoretical significance in underpinning your therapy work**
   - Stages of grief
   - Grief process
   - Exposure to videos/ or ( ) loss
   - Cultural differences in grief

b) **most helpful in practice, in sessions with clients**

- Stages of grief, grief process
- Experiential nature of training prepares well for sitting with the bereaved client

11 **From the material used in the training, was anything especially poignant which gave you insight into a bereaved person's experience of loss and grief?**

- Videos in maternity hospital

Visual material

- Photographs from funerals
- Experiential aspect – others' sharing experience

12 **What did you like about the training?**

Comprehensive materials, excellent experienced trainer, other trainees' willingness to share and be engaged. Confidentiality and safety aspects. Good preparation for work.

13 What did you dislike about the training?

Difficult to make time commitment – perhaps better to have half days over 12 days? Also, very intense – should work trainees about good self care. This is another reason I think full days are too much.

14 What more would you recommend to be included in the initial training?

Awareness of common themes other than bereavement, as even though bereavement exists, the struggle may be around dependency, isolation, rejection, unresolved issues, identity and depression etc.

15 What do you still use from the training to inform your practice?

- Assessing stage of grief; normalizing client's experiences
- Being open to difficult feelings; need to be emotionally available; good self care

9 What would you exclude from the training?

Not sure. I can't think of anything that wasn't beneficial.

10 What advice would you give to a peer who is about to start the 6-day training?

- It is emotionally draining – know your limits and look after yourself well; be aware of possibility of feeling exposed if you disclose personal experiences
- Engage with others and with material – it's a good way of learning about the bereaved
- Keep an open mind- bereavement work is not only about bereavement – stay open to other themes/ issues
- Your theoretical background will influence your work – think about pros and cons – adapt .
- Also, for trainees to feel encouraged to continually assess clients as my experience is that some clients would benefit from different kind of therapy and not bereavement.

Anonymous Questionnaire return; 3 years post WBS training

APPENDIX 18

Dignity and Beauty:

A Therapist's Tribute to her Client

A vibrant woman of loving tender nature, in her thirties, intelligent, kind, joyful of life, fun-loving, warm, mature, generous and wonderfully embracing of life and people. – A much loved daughter, wife and mother of two, a well liked and respected colleague, a valued friend of many.

I was told the church was packed at the funeral – aisles full of people standing in their horror and grief. How loved and highly thought of you were. The Unit received cards and donations from Canada, Australia, England and, of course, your beloved, native Scotland.

Four years on, I still marvel at our amazing relationship. At the intimacy, the in-depth dialogue with no time or desire for even a second's worth of social chit chat, the giving and receiving of precious moments, words and heartfelt looks. How the times of our coming together flowed into one long session as though a week or 48 or 24 hours had not passed since we last spoke. We knew the task in hand, the clear purpose of being together and you had your important agenda to get through. Our time was dictated by your body – how else could it be? – And, I was happy for this. It felt right. Occasionally, confidentiality was only provided by the flowered curtain pulled around your bed – and others who thankfully ignored us.

From you I have learnt what beauty and dignity truly are. I have been allowed to see them and be a small part of your intimate encounter with them. – And I am eternally grateful. The dignity of a woman fighting for her life, then later in preparation for her death. All at one time, I saw the dignity of dying whilst living every valuable moment possible and the dignity with which you watched your own body change and prepare to leave this world. I saw the dignity of a woman's life, of your life, dying in truth and awareness, in touch with your body, your thoughts, your fears, your feelings, your hopes for yourself and those you were leaving behind.Your dignity – of taking charge of things important to you, of wanting to know how it might be, of how you wanted to spend your time, of what you wanted to say and of meaningful engagement with the whole process and everyone in your life. Dignity in your very being, in the choices you courageously made, in your spirit, your soul and your relationship with this disease that would not let you live.

And then there is your beauty! What beauty, indeed. Beauty emanating from every word spoken – and not a single waste of a word – every gesture you made, every smile and sad look, every tear. A look and smile that acknowledged the past, the present, the future – the truth, human mortality and the polarities that you embraced so gracefully. – Your joy and zest for life and your reconciliation with dying, your immense pain and sorrow at leaving your loved ones and your courage in planning farewells, your relationship with a phenomenological experience beyond your control and the existential choices you made. I cannot adequately express what I saw and felt. Even now, there are times when I have nothing to say, for words are not enough to do honour to your journey. I just feel it and let it 'be', knowing that this experience will be with me always. My life has been forever touched. You let me see and understand about beautiful things.The inner beauty that cannot be destroyed by illness; the beauty that transcends the physical only to emerge even more breathtakingly beautiful in its truth, honesty and love.

Frequently with affection, we gazed intently into each other's eyes, reading the signals and checking each other out, both fully present and completely undeterred in our task by the kidney bowl held between us, intent as we were upon our journey and all the more united in our task by the significant contents of the bowl. On one occasion, I said: 'I'd like to hold that for you if that's what you'd want' and your reply: 'Yes, I'd like that', allowed me to hold the bowl while you braced yourself for each wave of vomit that surged through your weakened body. Time was precious, at a premium now and we were very busy with our work, both committed to fulfilling the task. The thick, brown, odorous, liquid-like tissue was no match for us. Our eyes acknowledged we were both aware of the smell and the gentle, wan smiles and slight nodding of heads that quickly followed, said we had both dealt with it. As our eyes met, there was also immense sadness and sorrow as we knew what this was – the breaking down of internal organs. I knew that I held between my hands part of your life force that had now left you and could not be replenished. That sudden and unanticipated realisation took me completely by surprise and, for a moment or two, I did not hear what you said. Although I was still looking in your eyes, my thoughts were frantic and I felt panicky. – The bowl wasn't good enough! What was I doing! Offering you this bit of card, shaped like a kidney? For a split second I thought it would be better to hold out my hands – at least they were warm, of feeling and of life. Then I wanted the bowl to be lined with beautiful rich, soft silk to receive its contents and for the outside to be gold, encrusted with jewels. It wasn't right that the bowl was made of thick, hard card and dull grey. Then I thought, 'thank God it wasn't the old stainless steel bowls' – cold metal! I couldn't bear the thought of that. – It just had to be a soft, gentle landing on a warm surface and so I became glad of the grey cardboard vessel. I consciously re-engaged with the present. I realised I was holding it with great care, with both hands, like a precious object. I forced myself to focus and hoped that you did not notice my momentary loss of concentration. How humble and privileged it felt – then and now – to be trusted with the very life force that was being driven out of your body, against your will but impossible for anyone to stop it. Words seemed so useless; the feelings and experience so intense.

I was glad you never ever asked how it was for me but trusted me to be able to be with you, unconditionally and to take care of my needs elsewhere. How blessed I was to be so trusted. And not only with your body but with your love for your own special person, your husband and the love of a mother for her children. Love that I have, yet know not fully – for mine has not been exposed like yours – yet you have shown me what lies deep within me. What a gift! – To have had even a glimpse of such love.

You asked me how it would be for your children when your death was here and what memories they would have of you. Would their last contact become their lasting memories? Would your children's memory of you be as you were then, on your cancer journey, or on life's journey?

- And so we talked about all the things you did together as a family and a mother: the spirit of your family union, of times talking together, laughing together, crying together, being angry with each other, sharing good, bad and difficult times together and, of course, those peaceful times spent on a beach in Scotland. We talked of values, beliefs, roles and role models and of the ways in which their lives would continue to be influenced by the significant and meaningful relationship between you. You took the opportunity to talk of their future without your physical presence. You found comfort in knowing their visual experience of your bodily changes would not be their lasting memories and in understanding that this experience of your illness would be a huge sad part of their lives. One which tells a tale of sorrow but one which does not represent the whole of their life nor of their experience of you, their mother. You wanted to

explore the grieving process for children and adults and again took comfort, knowing that grief has a character, a nature of its own and it is not only healthy, natural and normal for people to respond to grief, but it is essential that they be allowed their grief in order to reach a more peaceful understanding and place in their sorrow. – You understood the bodily changes, of which you were so anxious for your children, could be a significant acknowledgement and acceptance for them that the illness brought you to death and it was not you who left them. You had no say or choice in this. Remember how, on reaching this point, you lay back fully into the pillows, relaxed, relieved and exhausted, with eyes closed. This had become the signal between us that the session was ended and I left with a gentle stroke and squeeze of your arm. We never said 'goodbyes' or 'see you later'. And at our next 'coming together' a couple of days later – signalled by a particular smile and nod I had come to understand, you started with a direct, clear gaze as you spoke and said you had decided not to leave your loved ones with the worst possible visual image of your body. The outcome was inevitable but you had a choice in whether to keep fighting for as long as possible or give yourself permission to go. Just as before, over other things, you had made your existential choice. I remember saying: 'That sounds just fine'. And you had something else you wanted to explore. –

In your heart, you were certain your children were going to be all right. You knew the people in their lives and had done what you needed to do. But what of your own dear love? – You knew it would be harder in the long term for him and also that for him there would never be a right time for you to die. Extra time and more weeks would not make it any better or more bearable. This cancer; the pain of loss was hard. Oh so hard! And you wanted to say private things to him, important things, properly and whilst you could, still feeling in control of your words, your gestures and expressions. No avoidance of existential truth. No sleeping farewell. A waking farewell and again, you took control and made your choice. You had made your final decision, your most difficult decision ever. Our work was done and we knew that and my sharing of your journey was at an end.

When I returned from a week away, as I was sat writing up some notes, I was told by someone passing through that you had died. Although expected, it had seemed a bit sooner than medical staff anticipated. I remember nodding and only asked about the funeral later. For the moment I just sat quietly and repeated your name twice. I smiled at the memory of you. (I had had my moment of devastation at your dying, earlier in our relationship, long before your life came to an end.) So in spite of your strong heart and personal strength you had decided to transcend this physical world on your terms; when you were ready, when you felt the time was as right as it could ever be for those you love. In dignity and in beauty.

I will always know you. Although I was there for you, it is I who am by far the richer for knowing you. Your eternal gifts are precious and treasured by me. I will use them whenever I can, at every opportunity. I will use them wisely and well, to assist and guide me. My life has been deeply touched by you and my work as a therapist, trainer and supervisor has been informed and enhanced in a way I could never have imagined when I entered this profession.

- *And I thank you – for letting me know you and spend time with you, for your trust in me, for teaching me about dignity and beauty, for giving me insight into the deeper world of my love – love of a woman for a man and a mother for her child – for sharing your personal journey with cancer with me and for allowing me to join you at times on*

that journey – for all these eternal gifts that have meaning for the rest of my life and that I hold dear in love, respect and honour of you.

Thank you

'Emily'

Thank you.

APPENDIX 19

Transcript: Training Focus Group 4 2010

J. started talking as soon as she sat down and before any introduction prior to commencement of recording. Therefore, when I started the recording, I referred back to what J. had wanted to say.

For the purpose of sources for NVivo analysis, this transcript is imported into NVivo as three distinct sources: J as Jane; Al as Alex; Br as Brenda, each of which is a pseudonym. An accurately represents Anne, as the researcher.

An. So if I come back to you J. You were saying that your experience is a bit blurred.

J. Yes because when I started looking for a placement, I did start at Trinity Hospice and I did 50 hours of their training there and I did see a client there for nearly a year when unfortunately, em, the organisation wouldn't enter into a contract to make it a formal placement.

An. Right.

J. So, very sadly because I was well settled there, I had to leave and em I found another, it just happened to be bereavement, I wasn't specifically looking. I'd tried everywhere. I tried so hard. Em, it was at Lewisham bereavement service.

An. Mm.

J. So when I came here for the training, I had already worked for Oh! I think perhaps 6 or 9 months for Lewisham bereavement And em, there, clients are seen for long term so I hadn't seen many clients but the clients I had seen, they have six months and if they need more, it's easy to get more, an extension. So my recollections [(*pulls face and shrugs*)

An. Laughs pleasantly in response to gestures.

J. of your training, although I have some, are intermingled with things I already knew.

An. Yeah 'cos you already had quite a body of experience and knowledge around [

J. And training.

An. bereavement work.

J. It's a bit hard for me to remember where I learnt what.

An That doesn't matter. It'll, I'm sure that in the mix of it and general conversations that'll be fine. And actually, that's an interesting angle. You know that you did this and you already had quite a substantial amount of experience.

An. Mm. OK. Just to sort of kick start, maybe, I'm thinking about the diagrams used in the training and I'd be interested to have any feedback at all on them, or anything you think should be added into those diagrams. Anything at all.

Al. Mm. I still go back to them.

An. Do you?

Al Yeah. Every now and then. And particularly when I'm feeling stuck. Mm. (*small laugh*) I do go back to them and I have a look and sort of try and centre myself on what it, what the tasks are, where the client might be. It just helps to ground me a bit if I'm feeling that we're all over the place or I'm not quite sure. I think, 'what is it that actually we're trying to do here? What is it that this is about? Where are we?' And I use them when I'm writing up notes, I'll have a section on progress of meetings and I use those sort of headings and em to try and work out is this client sort of in shock or you know, or a bit of everything, or. So I do come back to it quite a lot and it does actually help me feel a bit more secure to have a folder where I know I can go. And, you know I can look at it and just think about where I am with the client.

An. Mm. So when you do that and you go back to it, do you go to the diagrams or do you go to written blurb?

Al. Mm. I do both actually. I sort of em, there's one page which is the tasks of grieving and then there's the diagram (*reference to diagram GE2*) and I've got one next to the other.

An Oh, OK.
Al. And I've got some hand written notes around the diagram [
An. From the training?
Al. From the training and so I tend to look at both. Em, and (0.4)
An. So do you find that helpful, then, side by side?
Al. Well they just happen to be next to each other in the way I've filed it.
An. Mm.
Al. I do look at that diagram and I em, there's the em, I often think when I'm with clients , the sort of, the jumping, going up and down (*makes movements in the air to describe the 'drop off' points on the triangle of diagram GE1)*
An. Yes
Al. That, that diagram em, sticks in my mind a lot when I'm talking to clients and saying 'Don't ex (0.2), we're not on a straight line curve here. That I do think about jumping around.
Br. I find it really helpful as well. And I actually use that diagram with the people in the session. I don't actually draw it out. Sometimes I think I should because there's something very (0.3)
Al. Concrete. Yeah.
Br. Concrete. Even have it, we should probably have eh little handouts of it.
An. OK.
Br And em. And I think it speaks to people.
Al. Mm.
Br. I don't know if it relieves the pain, or it just gives a hope
Al. Mm. Mm.
Br. But I don't see it as a false hope because [
Al. No.
Br. You are saying that actually you are working through that grieving process and there will be times when (*expresses sadness with facial expression*) but it speaks to them so I use that one (0. 6) (and nods a few times without speaking) **a lot**. And other ones that you were talking about and just eh, also normalising it for me [
Al. Yeah
Br. where they are and what's the work to be done. So I find it really helpful. And the one that, you had the one with em, the one (0.6) eh, brain. The amygdala ?
An. Yes, the amygdala.
Br. That's, that's really helpful as well. Just to think actually where they are and that they don't have any cognitive hooks and they're mostly in that fight, flight position and how that works.
An. Has that been helpful, to kind of put that in a frame em, about how it doesn't happen for the client. That they don't make that connection between cognitive stuff [
Br. Definitely. It has been helpful to me.
An. Mm. And when I did that diagram, I purposely didn't put in all the kind of chemical terms and names that go with it, that's to do with adrenalin for example and the cortisol kind of stuff. Em, because I thought that would make it too cognitive as well. Almost as if people **need** to know these names. My take on it is that we don't need to know those names and that level of knowledge about the brain structure and the chemical structure and the endocrine system. But would **you** agree with that (*to the group*)? Do you think that diagram works without all of that information or [
Br. Maybe it would be helpful to have, not, not too much but just em a little bit information about, for example adrenalin and what happens in the brain.
An. OK.
Br. A few bullet points.
Al. Mm. 'Cos I find myself wanting to know more about the neuroscience side (*small laugh*)

An. Yeees! (*joins in with small laugh as a recognition of similar interests*)
Br. **Yes** (*joins in with the shared laugh and recognition of interests*)
Al. And that's not, and that's not (0.3) and I think that's something to go away and maybe do on my own but it would be good to have a reference or something to (0.2), or this is a good book, or something to put it in context.
An. So it might add, so although it wouldn't be a diagram full of lots of words thrown in but maybe pin it to a few key things like the endocrine system and adrenalin. So tap into the neuroscience. When you're saying that, it makes me think that would be perhaps very em, useful for counsellors/ psychotherapists and probably the police and so on but not necessarily the funeral directors or (0.6) I mean, I'm making an assumption there! (*flicks eyes upwards and purses lips*).
Br/ Al. *Laugh simultaneously as I catch myself making a discriminatory assumption*.
An. I don't know. But it may not be for everyone. So there's something in there about thinking about for whom would that be really helpful, appropriate [
Al. Yeah
An. and for whom might it be less so.
Br. Mm hum.
An. Yeah. So that's something to think about. –(*ANNOTATION here re J's lack of engagement).*
An. Do you remember the diagrams, J ?
J. Em I do remember them but I have to say if there's a choice between diagrams and numbers and words, I'm a person who prefers words.
An. OK
J So I refer often to the wording you gave us, acknowledging the loss, feeling the pain and withdrawing and reinvesting – ANNOTATE on second coding. Also when I'm doing the final reports, I find the information you gave us really, really helpful. But no, I haven't referred to the diagrams. Though listening to what the others are saying, I think perhaps I should have a second look.
An. Ugh huh. I know that the one, the one we were discussing before the trauma one, the one with the triangle and the 'drop off' points and that, most people find that really kind of quite helpful and as you were saying Br., you can actually do that with the client in different formats but it doesn't have to be complicated, you can simply go like that and do things like that, or just a blank sheet of A4 and an ordinary pen. It can be helpful. ANNOTATE – my researcher versus trainer role!
J. Yes
An. And I think Br. You used the word hope and I can see that.
Br. Yes. I've used it with almost every client.
An. Have you?
Br. Yes. At one point. And they've found it helpful. Definitely, definitely.
An. I heard you say as well that maybe we should have that in some sort of [
Al. Form.
Br. I think, I think that would be quite useful for people that feel comfortable using it. T o have it even in the office where we have the admin stuff.
A OK. Well that's like a recommendation you're making. Would you (looks at others) endorse that?
Al. Yeah. Yeah I would. I think it is (0.2) I mean, I haven't used it. I've described the diagram around things but I've never actually given that to a client.
An. I suppose one of the things about it is that because it doesn't actually, well there are words in the middle of the diagram that are used in training but that diagram can stand on its own

without any words so in a way I could see why you're saying that (looks at Br.) because it doesn't have to be theoretical, it's more of a practical knowledge [
Br. Yes.
An. thing. A practical knowing about, you know for them, rather than trying to give a client theory about bereavement which is not what that diagram is about. It's about their actual experience of (0.2) Yeah, that makes a lot of sense. That could be useful.
J Maybe there could be a progression of them, a simple one for em, those who only wanted to look at the basic and then progressing to those who would be interested in the chemistry of what is happening in the brain.
An. In the trauma one?- (*ANNOTATE: researcher's awareness that participant J is referring back to earlier discussion and not cognitively attuned to present discussion).*
J Yeah
An. Yeah, OK. (0.3)(*Awkward silence; Al and Br looked downwards*.)
An. Em, I 'spose in my head, I've got various aspects. I've got things like em what **more** should have been said in the training? What have you gained from supervision that you feel should have been in the initial training? Or, what through your supervisions has flagged up for you that here was a gap in the training; something that didn't happen or wasn't discussed or wasn't brought into the training? I'm aware that you know there's a practical element here in how much can be brought in in a short period even though it is very intensive. But it's about trying to have an awareness around what those things are and then maybe I just need to sit and reflect. See how it can be jigged or whatever. So it would be really useful if you've got any bits around that.
Br. I think what speaks out to me, after I finished the 6 day training, and obviously this is a specific type of counselling, and you work with bereaved people and it is quite em, shocking initially just to hold somebody's pain which is huge and em. Just thinking afterwards what maybe might have helped, (0.4) maybe 12 is not enough. That's what I feel and it's just ongoing theme for me 'what really can I do in twelve weeks?' Maybe just (0.1) Now it's different obviously, I've been doing this for 2 years so I found my way but maybe initially to almost give little guidelines – 'you've got 12 weeks so in first 4 weeks work more on this then middle stage (0.2). I mean we did talk about beginning, middle and ending, um, but almost more guidance for us counsellors because we are taking on board quite a lot.
An. & Al. Mm. (*simultaneously)*
An. Yes
Al. It's eh
Br. I don't know. I get then into history and then you have to think 'oh no, but let's stay with the actual bereavement and of course you don't want to miss anything out. Of course you will but [
J. I agree with Br because coming from Lewisham where I said earlier we could have 6 months plus, I found it terribly difficult to have 12 weeks at first and moaned endlessly about it in supervision. And I have got, I'm surprised how used I've got to it now. I've sort of forgotten about the 6 months and so I (0. 5). I've had a lot of help in supervision, thinking about it as em a client has done some work before they come to you, you're only with them for a little part of the journey, they will do more work later but it does put pressure on you to feel you've got to achieve something within a confined space of time. I'm getting slowly, slowly rid of it and em I agree with you some sort of input and there are things and you know you can feel confident about it. It is not all impossible and difficult.
Al. But can you give, I don't know that. I think it would be very difficult to give guidelines about what you can achieve at various points along the way. Other than to really remind people that it is 12 weeks and there is that pressure of feeling that you've got to do something but actually you've almost got to recognise it and set it aside because you could, well I''ve had

clients where I've achieved virtually nothing in 9 or 10 sessions, then suddenly something's been achieved because that client was ready at that particular point to do it. And so I don't know, I would have thought the risk of guidelines in terms of saying you've only got 12 sessions, you know 1 to 4, beginning, middle and end is that you can be forcing a pace that isn't, that isn't helpful for the client. I don't know how you'd get round [
J. Yeah but something in the training about the limited time [
Br. Maybe not strictly guidelines but [
J. No but maybe how to deal with it.
Br. But in every counselling you do have beginning, middle and end and you need to have your feet on [
Al. Yes and to remind the client perhaps where they are and I think sometimes that can help the client, you know we're at session .. this is our 10th session together to have that kind of focus that's, that that can be useful in terms of always being aware [
Br. Maybe tips rather than real guidelines
Al. Yeah, where are you.
Br. But tips that you can give.
An. Mm. And I'm thinking as well, I mean it feels really important you know for you and certainly it was then when you first took up the client work, em to actually suddenly be launched into this twelve week thing.
Br. Al. Yeah
J. It's a big step, I think it's not such a big step for those who haven't had any placement as for those who've come because several of my peers at college are on open-ended placements for bereavement as well, some agencies do that. And I think it's much harder coming from open ended or six months.
An. Moving from one [
J. To the short one, yeah.
An. And that's your experience of doing that?
J. Yeah.
An. Mm And to come back to your experience (Al and Br),It does feel really important, your initial experience. So in the training, you've had all this information, [
Br. Yes.
An. a lot of it about the trauma and the deep emotion of it, you've been exposed through the training material to – I think you (*looking at Br*) used the words 'very painful' earlier
Br. Mm. Ughuh.
An. and then suddenly you've got 12 weeks folks. I can see what you're saying. It's a bit [
Br. I think it's, it's, it's [
Al. It's a pressure.
Br. It's of course at this point, it's a different story. Now it's 'I've done it'. But I'm just thinking when you find yourself at that stage, at the beginning stage.
An. So how did you do it? (*smiling)*
Br. How did I do it? I think it is in a way hit and miss. With some people you, well of course you, again follow people. Somebody wants to plunge in one way and I think also, I work integratively so a huge part of my work is developmental stuff and maybe that's where I need to put (0.5) my tendency is to go there but then I have to go back, oh! We don't have time for that. And I've noticed that I, you know you open up certain things and then (*opens hands*)
An. Yes (nods) Because life is very complex. We all are. Peoples' histories, peoples' stories can be hugely sadly connected throughout their lives with difficulties. And it's hard to actually box that off. I think that's what I'm hearing you say. That actually it's almost as if you're required to box all that away and my guess is that that feels quite antithetic to who you are as a psychotherapist.

Br. It will be hard for me to put it all away because that's just part of me, how I work.
An. Yes, absolutely.
J. I had actually forgotten it but I'm remembering how it was at Lewisham now and the sense that there was just time for the clients feelings to unfurl and it was a very luxurious feeling compared to what we have to contend with now.
An. What you have to contend with here? (*Question to J but Al jumped in to respond*.)
Al. Yeah but I also think that's partly, when I think what it was like starting. I think a lot of managing that sort of pressure and thinking I want to be through the 4th task by the time I get to the end of 12 weeks
Shared group laughter
Al. was using supervision. It was going to supervision and sitting with people who were experienced around you. And my supervisor saying 'well whose agenda is this? What's this about?' was actually one of the things supervision was most helpful for. You know, take a step back here.
An. That makes it sound as if having supervision actually in the service has served a good purpose in that respect.
Al. Yeah
An. 'Cos I think there are issues around supervision. I mean it would be surprising if there weren't, in any organisation. And I think there will be here as well. You know, even if it's how does that match up with your course orientation or course expectations. And also the experience etc in training orientation of the supervisor. But it sounds as if that is quite a useful dynamic of supervision that at least you are [
Al. And I think there's something about, I think for me in a group, I know that there's perhaps questions that I, with a group of experienced people around, that I probably would have thought were a bit stupid or you know initially going to supervision but I don't feel that so much now but I think when I first started I was quite aware of not wanting to appear really em, to ask stupid questions and what, you know but I think that's just something you learn to get over, or it's something I learnt to get over.
An. Mm. I think when any of us start, it's new and there's always that awareness of what is it that I don't know that other people do?
Al. Ah! Yes You **do** do that, don't you?
Br. Yes (*laughs in recognition, simultaneously with Al*) }
An. So we've all gone through that!
Br. But yes I do agree; supervision is also a really holding place.
Al Yeah (*nods*).
Br. Just hearing others and not feeling alone.
An. Yes and I think we can learn just listening to somebody else's case load or client histories. It's generative learning where we learn from their cases as well.
Br. Mm. And I think that was so, so beneficial. That's what you did in the training. You gave us a lot of case studies and working through them. I thought that was brilliant. Really preparing you what to **expect** and working with people and having that **sense.**
An. Did it do that?
Br. I definitely do think that was [
Al. It was a real wake up call actually. It was a real (0.2)
Br. Yes (*nods*).
Al. It was a real; I can remember doing particularly the trauma cases and I thought, do you know, actually yeah, I could be sitting in a room with somebody who has watched somebody burn to death in a car. Can I do that? And I think it is really important at that stage in the training to, you know, that you're shocking people in a way [
An. I know (*said softly, acknowledging the awfulness of the traumatic material*)

Al. and asking them to consider, can you, can you do it, do you think you can sit in a room with somebody who is going to bring something as horrific as the things we looked at. Because I, you know at that stage, I don't think everybody can. I remember asking myself can I? Do I think I'm up to this?
An. So you feel it is appropriate for me to introduce that kind of material in the training?
Br. Yes.
Al. I think it's more than appropriate. I think it's essential. Because you don't, if you don't have that at that stage of the training and it happens to you further, you know you don't realise that it's, you know if you sort of read the annual report or something and you assumed that actually the most likely client is somebody who's a parent who's had cancer, you may well think 'oh I can do that' but actually (0.2). Actually, I have more recently had some really sort of horrific, particularly suicides and I think I knew at some point the client with the horrific death was coming and it's not a surprise to me. Em [
J. I do particularly remember the commenting on the time, of the time of day that you had trained us about it. I remember it vividly. It was a Friday night and it was dark and it was pouring with rain and do you remember? (*looking at Al)* And we were all [
Br. (*Pulls head back in surprise*.)
Al. (*Small laugh)* All I can remember is the accident outside my house.
J. Yeah. I went home and I was, I couldn't cross the road in my normal, maverick diagonal manner but had to hover on the crossing absolutely terrified [
An. Gosh!
J. of what was going to happen to me. (Br and Al look surprised and a bit shocked.)
An. Oh wow!
J. And I remember commenting to you that although this was really useful and valuable input, I think it would have been better to put it in at an earlier time in the day's training when we could have been debriefed as it were and calmed down before we were thrust out into the night.
Br. (*Frowns and grimaces.)*
J. Because we were all really freaked out weren't we? (*To Al)* Do you remember?
Al. I , well, I remember it very well cos I went home and then a woman had been hit by a lorry in my street and I went home and there were lights flashing and sirens and this woman was trapped under a brick wall by the lorry just near my house. But it did bring it all home to me and made it very real in a way that I think is really important, that this isn't just something you do to get through your course. That this is hard, difficult and sometimes very traumatic work and if you're not prepared, you know, if you think that's going to be too difficult, you need to know it then rather than, you know, later.
An. I remember that -when we came together on the Saturday morning and we had the opening debrief from the day before - I remember you saying in the feedback and closing session on the Friday, that you had felt during the day 'is this, all this trauma stuff necessary?' And you were kind of like questioning it - in a healthy way, questioning it and a positive way, questioning it – and then you couldn't believe what you'd met on your way home.
Al. I know!
An. It was such an ironic (0.2), the synchronicity of that was amazing really. I remember you saying you then thought 'well, there you go!' [
Al. Yeah
An. 'That's my answer. That was just down the street from me'. Yeah, yeah (*quietly).*
An. But I hear your comments as well (looking at J.). Actually, with groups that I have trained since, I have put in more psychic protection exercises and I've actually em shifted around some of the trauma work as well [
J. Ughuh. And have they commented on how they found it?

An. Yes, yes. And I think it's worked out. And also I've taken more of a vignette approach as well for the trauma element and am focusing on the poignant stuff. I do introduce the case studies and I do use them but I have re-organised them in how I deliver them.
J. Yeah I think that's good.
An. And I also took it to my own supervision. Em it was something I took which will be a part of my, in my write up as part of my research as well. What came out for me as I really tried to stand back and reflect upon that, is that because I am so familiar with this material – I mean I know it like the back of my hand – and I don't know if it was your group or your group (hand gestures), but in one of the groups, (in an end of day debrief) someone suddenly kind of interrupted me and said something like 'Anne, I'm amazed: you've been training all day and you've not looked at any notes once.' And it's true because I don't need to because I know the material so well.
Br. & Al Mm.
An. But the issue for me was that I, I was reflecting upon it (the participant's comment) and thought I am so familiar with this, I am almost de-sensitised to it in a way [
Br, J, Al Mm, Mm (*simultaneously)*
An. And what I wasn't doing was standing back and thinking I'm introducing it to other people who, for whom, maybe it's the first time. So the feedback from you is that the material is essential which is what you were saying Al but I need(ed) to reflect more on the delivery of it.
J. Good.
An. So I used a whole supervision session, an hour and a half supervision, individual supervision, to kind of process that about what's going on and my supervisor was very challenging. Really challenging so that was very useful and I've taken it on board. So the material's all there but actually I'm coming at it from a different perspective.
Al. I still can't get the burning car. Sometimes I still have mental flashes of it. It was quite (0.3) [
An. The witnessing one? Witnessing traumatic death?
Al. Yeah.
J. For me it was the person whose inner organs were splattered all over the wall. I remember waking up on Saturday morning and cos I think in words, I was still thinking in the words of that and I can still vividly remember that.
An. Is this the disembowelment case on the underground?
J. Yeah. (0.7) No. The one whose partner (0.3) they, their organs were splattered...
Al. It was a cancer death I think.
An. Oh yes. In the bedroom?
Al. Yes.
An. Mm. And you see, there are a couple of cases where that, where similar types of scenario and those deaths are regarded as an ordinary death. (*ANNOTATE i.e. not traumatic, but a domiciiary death)*
Al. Mm
An. They're not regarded as a trauma or they're not identified as such. Those deaths are within the realm of normal, everyday life kind of events, as opposed to disasters or horrors of disaster stories that we hear about. But the point about it is that the impact for the bereaved person is that it, well, how more traumatic can it be? So that's why those are there.
J. It's funny noticing that a particular story and there were several, you know one really struck others, another others.
An. Mm It is interesting isn't it? (*Annotate here – individual differences / personalities.*)
J. Yeah.

Br. I don't have a recollection of any of those. I just remember thinking how useful it was just to have a case study and really get some kind of taste of 'what am I going to embark myself into'.
An. I think for me, the motivation is to do what you've been flagging up which is that actually you do need to know because it would be such a shock. Very often our understanding of bereavement work doesn't involve, well we wouldn't ordinarily expect it to involve those sort of scenarios and yet that is the very raw material that you could find yourself working with in terms of it is actually the trauma you are working with and not the bereavement around the circumstances of the death. And I think It is about trying to alert people that if you come into the work – and certainly if you come to WBS – that is what you are going to encounter at some point. That's just my take on it and I wonder what your view is of that.
J. Oh yes, very much so. But I think it's really good that you've changed how you present it in a certain way.
An. Reflected upon it and changed it. Challenged myself with some of it.
Br. And I remember also what was really useful and I see as essential for the training is self care.
An. Yes
Br. What do you do afterwards with all this material. And I think a lot of people that join, we're all in either the second or third year of training so you're still (0.3) and we did have a little bit of demonstration of what are the different ways you can help yourself after the session.
An. Mm. You did. Do you think there should be more?
Br. Maybe a little bit more. Maybe, maybe a little bit more time allocated to that.
An. Mm. Mm. (*nodding)*
Br. 'Cos it is quite heavy and it is quite intense and [
Al. I've no, I don't really remember it although I'm sure it was there. But I don't remember it and that maybe to do with what I've retained [
J. I don't remember it either.
An. Well then that says something doesn't it.
J. Maybe there wasn't time for it.
An. Well there's always something in there but maybe (0.4) because that's something that I (0.2) I mean that's a really good point you raised it em because what you're saying there as well Br is to make it, give it a higher profile. So in giving it a higher profile that means that I would then ensure it didn't get **lost** in the material because what \I do do, my attitude in the training is to be very flexible.
J, Al, B Yes (*simultaneously).*
J. I noticed that. It must happen that sometimes an interesting discussion arises.
An. Absolutely. And I will always go with it because I feel that's appropriate for the group [
J And that takes up a lot of time doesn't it? }
An. Yes, but it would mean possibly that I leave – sometimes I don't get to introduce all the case studies with every training group and that's one flexible angle – but the other is the way discussion goes and snowballs into whatever. So that's a time when maybe something like 'how do we look after ourselves and protect ourselves' , if it doesn't have the high profile attached to it, then maybe that's something I can allow to slip away and not address it. Whereas, I think you're right, to make it a stronger profile in the training means I would never then, you know if that's flagged up in my head as being essential, then I wouldn't let that go by the board so to speak.
Al. And I wonder if there's, I think one of the things I felt after training – and we'd spent very intensive 6 days together – and then we go off and we never really see one another again although there is supervision but you lose contact with the people you train with. So I don't know whether there is room for a sort of 6 month short meeting for an hour or so to say how's

it going, or for a catch up, or does anybody feel they need anything. Or whether it's done under a training banner or just an informal get together. I don't know whether that will work but it might catch gaps that people might have.
Br. Yeah. I was thinking along the same lines. In that first year after the training and once everyone's started seeing clients, I think that's a really good idea. Maybe after 6 months.
An. OK and who would you see as facilitating that meeting?
Al. I don't know. It could work in 2 ways 'cos as I say it could be an informal catch up, reconnecting with people or it could work under a sort of more formal training banner in terms of how are you all getting on? I don't know it could work both ways to probably generate something that is useful but I do remember that first year and feeling sort of a bit, well obviously you do have supervision but supervision is once a month so I do remember sort of having that sense of going out, starting the work and then once a month you'd see, you'd meet your supervision group. My supervision group changed a lot for various reasons. It was never the same people for about the first 6 months. It changed **every single month**.
An. Oooh! Gosh!
Al. And so it felt a bit bitty, you know for all sorts of particular reasons but it felt I was the only constant factor (laughs and group joins in) in it! for about 6 months. But I did feel a bit kind of, sort of as if I wanted to see somebody I knew.
An. Mm. It feels a bit isolating.
Al. Yeah. I did feel a bit, everything was new and so, perhaps my circumstances were probably quite specific. You may not have felt that at all (*to J and Br*).
J. Em, I would have welcomed more get togethers even so. Em we were at the AGM weren't we and somebody had put in the suggestion box the idea of everyone getting together a bit more and I think that would be really good. And another thing when I was at Lewisham, 3 times a year there were training days and an outside speaker was invited and they were really, really, good and you felt you were on a continuing learning process which we do actually need to be on because there's so much to learn.
An. Yeah absolutely.
Br. But maybe it would be better here to have 6 and a half days of training so the 6 days what is done anyway and another half day, especially for that within 6 months and for people to feel I can have that space to voice or to hear other people. When I joined my supervision group, there was no-one else from my training so it was a completely different group. Eh but regardless, it would be good to have within the first 6 months. Preferably that mainly you come.
An. I can see that that makes perfect sense.
Br. But of course it depends as that is time commitment for you. Whether that would work, or...
An. Mm I think that's academic in a sense at the moment. I think the important thing is what you're saying is that there is a connection between having gone through the training and there's a connection about 'how's it going?' and 'what's not going OK? It's a follow up.
J. Yeah
Br. Yes
An. It's a follow up on the training so it makes sense that it would be the person who does the training.
(0.5) Silent pause.
An. I don't, I think this is something that I'm bringing in because it's something I'm aware of in my own work and what interests me in my own work and particularly bereavement work, is the sort of issue around personalities; personality styles and character styles. And, of course, I don't say anything about that in the training because it's like it's another whole area and it's like where do you stop really.

J. What do you mean? Counsellor's personality styles? ANNOTATE: Aware I had not said counsellor's.
An. No. Well, our understanding as counsellors and psychotherapists around personality development and character styles and like Johnson's work on character styles and so on. And it fascinates me in my own work with people generally, not just bereaved people but, I don't mention it. But I'm just wondering whether you have any views on that?
Br. I mean, I use a lot of Johnson and Lorna Benjamin Smith.
An. Ughuh.
Br. But I **think**, had that been introduced to me initially, I would have freaked out because **now** (*in 4th year of MSc Integrative training)* **,** we are doing that through, through my college [
An. Yes, yes (*and nodding*).
Br. we use that a lot in my primary supervision because it is never talked about it here. I have never heard anybody talking about these (personalities) so I think I would be overwhelmed and at the initial point, not knowing the diagnostic bit at all.
An. Mm. Mm. (*nodding*)
Br. Em, and it takes, it takes quite a lot of time to really get to understand so I don't know and especially we are not using diagnosis here.
An. No. Absolutely not. No, not here.
Br. No, exactly. But for the purposes of my college, I do.
An. I'm very pleased to hear you say that because that's my thinking around it and my, my conscious awareness of never talking about it in training is 'what would I be trying to do?' because that belongs to a theoretical training that people are already on. You know, you're on placement here, you know and it's almost as if, well if, if I did bring that in, why wouldn't I bring something else in?
Al. Like a (?)
An. And something else again. So my thinking around it, my philosophy around it has been to leave that with the different training institutions to which you all belong. Em, but I 'spose I just had it as a question and wanted to raise it,'but has that been a bad thing to do?'. But from what you're saying, I'm really pleased to hear you say that actually.
Br. You did bring Bowlby's work, I remember that and that was tremendously useful.
An. Right. Just about that much of it! (*Gestures a small measure.)*
Br. Yes but what you brought was really relevant. It was really relevant. Eh maybe a little more of that because he does talk about separation and loss.
An. Yes. So I think you've answered another question, another query that I've got going around in my head 'cos I'm aware that when, if ever I mention Bowlby or attachment or whatever, I always do it you know as if I'm sort of holding up an inch but whereas actually there's **miles** of Bowlby's work on attachment and not just Bowlby's, but you know all the other people which came after as well, and Alan Schore's work too. But, again, it's a conscious decision not to go there theoretically because it's too big, it's too vast. But what you're saying is that the bit I did bring is useful.
Br. Yes. It was heart of the matter for us.
An OK, well that's, that's useful to know**. And**, a bit more on attachment for the future.
Br. And those videos, if I might just say a little bit about.
An. Yes, pl::::ase do.
Br. This has just come into my mind. The videos were really, really useful.
An. OK.
Br. We saw 2 or 3 and they were really useful.
An. Can you say why?
Br. I think one was the Tavistock (*clinic)* one. I guess just to gain perspective, em from these bigger institutions what is it like and then, em, I remember [

J. I remember one about a baby }
Br. One about a mother losing a baby
Al. Yes, the 'Empty Arms'.
J. & Br. The 'Empty Arms' }
J. That struck me particularly as well. I found that really useful.
Al. Yeah, yes.
(0.4) Sad, silent pause
An. And I think because it's a visual thing as well isn't it? So it's, it's real. It's there in front of you.
Al. Terrible loss.
An. Yes and It's the reality of it; it's not just talking about, it's seeing it. And did I play the Madonna video?
Br. Yes, in our group you did.
An. 'Cos in some groups, I, I – this is the bit of the flexibility, that sometimes I might not actually do that.
Al. There was the video of the couple with the rather stern, em (0.5)
An. That's the Tavy one.
Al. Em, em, em
An. The psychoanalytic psychodynamic couple therapist.
Al. Yes.
J. Oh yes! Oh! (*facial expression of disapproval*)
An. That's always good for discussion, isnt it? That generates [
Br. Yes, it puts things in perspective. It really does. Does that style fit?
J. And I think any training would video like, video and a bit of going away in another room and a bit of input from you. Breaking it up like that is always good cos it keeps people alert and interested.
An. So did that, following up on that J., did that em, breaking up into the small groups and asking you to use the counselling rooms for small groups, did that work for you?
Al & J. Yes }
Al & Br Yes, definitely.
Annotate – I sensed tiredness.
An. I don't want to keep you too long (meaning more than agreed time). So I'm just going to say 'is there anything else in the next 15 minutes that you want to put in that I've not raised, anything at all, that you think is useful for me to know and reflect upon?
(0.23) Silent pause.
Al. I was just thinking in terms of I know whenever over the course of the last year, when I've had male clients, I've sort of found it harder than you know female clients. The male clients I've had (0.2), I know we did some training on em difference and diversity. Em, but I don't know whether I perhaps would have liked a bit more em, working, you know working with men. Both the male clients I've had, have been black males and so I think for me it's been, it has been (0.2). You know, one left very quickly and one is on-going but you know, how you think, how you actually approach that, how you work with understanding from a man's perspective what it's like to be in a room with a female therapist, or white female therapist and em understanding. I know we did, I know we did some work on diversity and what different cultures mean.
An. Yes.
Al. But I think there gender, there is a gender dimension in terms of being in a chair to, I'm not explaining this very well and (0.3)

An. You're right. And listening to you, I'm aware that I don't particularly address the gender issue within the diversity that I do refer to or bring in to the training. I don't particularly flag up gender difference.
J. And I could add gender and age because I've had 2 elderly white, male clients; one 81 and one 94 who was 95 during the course of the counselling. The 95 year old was actually brilliant. He could get in touch with [
Al. I, I [ ]
J. quite a lot of feelings. Yeah, he really was, you know, a, I felt very privileged to work with him. But there is a an age thing; especially with men. Em, you know different generations of stiff upper lip and not sort of speaking and not beginning to think how you feel, in a sort of 'big boys don't cry' kind of way. I can't actually remember if you address age specifically?
An. Em, I in the training it tends to be, I give one sheet as a handout which is em, on working with the elderly but it is a psycho-education sheet so it's the same one that I devised for Age Concern in Wansdworth. So it's more bullet point kind of stuff. But within the training what I do do around it, is to flag up the additional vulnerability very often of the older age group and particularly older men who are widowed and flagging up potential risk factors, not of actual suicide but it's about not looking after yourself. My focus tends to be around watch out for people who, and not just men, say have diabetes and em, stop taking their insulin or stop taking their angina tablets and so on. That tends to be how I've focused issues around the older person plus case studies used do include older people and when presenting the diagrams, I also include older bereaved people within the examples of theoretical concepts to practice.
J. Well, my experience of these 2 is 'what is counselling?' at the beginning. 'Oh I suppose it is someone to talk to'. You know it's not their fault, they have no other concept of what it could be so I don't know, may be you could introduce a little snippet of what that could entail.
An. OK. Right. So this might become a 12 day training. (*ANNOTATE: my irritation self awareness – used laughter to diffuse awkwardness I felt and what I perceived others to also feel*).
Group laughter.
Br. They will curse us later on. I was just saying, you were mentioning gender, you said age and now I'm going to cultural bit (*group laughter*)
An. That's lovely.
Br. Em, Maybe just to have em statistically who attends the service and then just have little bit better understanding of cultural part of those people. I've had a lot of clients, Indian clients and it has been something for me to learn about, em, it's different, it's slightly different way of approaching and understanding and so maybe it wouldn't be a bad idea to have statistically who attends and get, learn a bit (0.2)
Al. This is all in the report. There is definitely the report, the annual report.
J. Yeah, yeah.
Br. I remember you talking about (*to An*), we did talk about rituals in some countries. I remember vaguely that we did talk about that.
Al. Not going to some, some people not going to the funeral, not attending funeral in Muslim society
An Yes.
Al. But yeah. Oh and traditional Jewish - I do remember that, yeah.
An Yeah, but I'm wondering if what you're saying is to actually again, give it a very specific slot whereas what I've tended to do is, is to just let it be part of, so there'll be more of a cultural reference if there's a case study around. So one of the case studies I use is around the Muslim young man whose acculturation process is, is very much westernised. Em, father dies suddenly etc. and then there's an added complication for him which is that he's gay. So I use that and

we then talk about Mulsim funerals and the fact that he didn't (*details omitted*). You know, so that and some of the other ones; a Ghanaian funeral with photos and so on.
Br. & Al. Yes.
An. But what I do is weave it, in and out so I guess it doesn't have that very specific focus and I'm interested in what you're saying about bring some of the, 'cos the statistics are there.
Br. Mm. And I also think it's also about this political aspects of self.
An. OK.
Br. And that's what comes into the room.
An Yes.
Br. Inevitably. And I think Andrew Samuels [
An. Ye::s. (*smiling*)
Br. I attended one of his talks that really spoke to me. Just understanding that sense, cultural, racial bits and difference and how do we work through it, with it.
J. Can you (to Br) remember something specifically that you've encountered in the counselling that was cultural?
Br. No, no. Not really. But just actually remembering that I've had 5 or 6 [
J. 5 or 6 Asian people?
Br. Asian people and just learning about that grieving process for them and how do I work with that too? Even to stay with it rather than [
Al. Well, well, well, that's what I was just thinking about, the kind of the idea, that in particularly, the em, with the sort of perhaps for a black male client of being a man and kind of actually blocking feelings and not expressing them and finding it very, very hard to, and coming to counselling but actually finding it very hard to override years of cultural pressure to not go there, to not cry, to not get upset, you know being aware and trying to work with that because it's, it is difficult to do that. How do you work with somebody who you know has never really done it and is finding it incredibly difficult to do it.
An. Mm. And when you're saying black, is that Black Caribbean or African?
Al. Well I've had an African and a Caribbean client where it was very much an issue in the room and almost the idea, and almost a paradox of thinking 'well you've come to counselling but the idea of why would it be helpful to sit in a room with you and get upset about these things and bring them up? Really, trying to get round that.
Br And I had a client, Black Caribbean. Exactly what you're saying. Very blocked and really very hard to start working and get to connect.
An. And your experience of that is, is that it's very much the cultural influence and their perception of 'self' and [
Br. From what I know about him, yeah that was there, that was the part of it.
Al. There was a strong element in there, I mean it's difficult to know how much is defensiveness to protect themselves from the terrible events that have been going on around them but at the same time, it's quite, it's very, I found it and I'm finding it very hard to think, how do, how do we work around this? How do we (0.3) What does the client want from this process because sometimes they **don't** actually want, want to get there or to think that it's (0.3)
An. So that would be really useful then to actually have some, maybe case study around that, some discussion around the case study, around those difficulties about actually working with the therapeutic relationship and the therapeutic process, em with specific cultures.
Al. And I think that, you know the statistics are that black males are one of the most likely groups to drop out of counselling em, and certainly my experience was that with one client it ended sort of after 2 sessions and I, and I was really dis-, I kept thinking 'what did I do? What? What? Em?, Em?. But I think it's, and I think you do, I think that was part of the training, I think there was something in the training to say, you know, that it is out there and that's what can happen.

An. Mmmm.
Al. And I think it's really important to xxxx, that we understand some of the reasons why that and how can we really help to, you know (0.3)
An. Do you think it would be useful if actually if that part of the training anyway was delivered by a black person, a black therapist, trainer?
J. Yes, I do.
Al. ***No.*** Not necessarily.
Br. Not necessarily.
Al. I had diversity training at college, on my course and I, there were aspects that were helpful that we could see it from a different point of view but also there were aspects where people just didn't say what they thought.
An. Ah!
Al. You know, I felt there was a lot going on in the room that wasn't being said because people were embarrassed to ask, you know, the question whereas they wouldn't necessarily feel that way if they could think of saying 'Oh Anne, with black clients, what has your experience been?' But you're almost wanting, it depends on your audience, but you're almost, you know what I'm kind of wanting today is how do you, you know, how do I get over the difference? I don't necessarily get there. You know, I'm not sure you always get there from em, having a black lecturer delivering it. You do get something else.
Br. Maybe if, actually I said no but then I thought maybe if that person is really just a focus on that cultural bit how what's done, you know, back then, how people are back there, I'm thinking in their countries of origin, probably because **I,** I'm from a different country but being here now for many years. But maybe in that sense it would be useful to get at first hand, to talk about but then not again necessarily because [
J. We had someone at my college just by chance because one of our tutors was ill for almost a whole term and we were really fortunate because we had this gay young black guy. He was like an all dancing, all music festful wow, wheeled in on a carnival float. He was **great!** And he really stirred us up for difference and diversity was his subject and he really knew how to press buttons. I'll give you a small example: we all 20 of us had to give an example of when we were, em, when we felt completely alone and I remember giving the example of going to a black colleague's wedding and being the only white person there and how it felt. And he was great, really, really useful and stuff. So, you know, from my experience, I guess it would depend on the audience but also what the trainer can do.
An. Yeah, I guess there's a lot of issues isn't here because I think what you were saying Al is that maybe the way that particular person was, different to J's experience, it actually was inhibitive to the group being very transparent about some of their issues and that kind of like, walking on eggshells, feeling a little bit (makes oscillating hand movements) [
Al. Yes.
An. Well certainly there's a lot there to think about and so on. Em, yeah, so it feels as if more of the influences of culture, race, and ethnicity actually in connection with working with the therapeutic process. 'Cos I 'spose that is something I, again I don't spend much time – hardly any – on actually the therapeutic relationship. I mean obviously we talk about it as we talk about the case studies but there is not a focus on the therapeutic relationship, in the same there isn't on personality character styles and so on. It's something I'll have to reflect on.
An. Is there any other thing? Any other comments or suggestions? Positive? Negative? Critical? Anything?
Al. (*small laugh*) I thought, I felt we were all well trained. You know, I genuinely felt we were kind of prepared [
Br. Yes. Definitely. I agree.
Al. for going into it.

An. Ooh! (*quietly)*
Al. You know, I've not, I have not felt at any point during the process here, unsupported or as if there wasn't really somewhere I could go or you know, the supervisor's always been there when I've needed a supervisor out of session.
An. Mm.
Br. And you've said we could contact you afterwards if there was anything [
Al Yes. I, em. You know, I think, overall I think it was really great.
Br. It was great.
An. And that's really nice to hear. And I think where I've gone with that as well is, 'cos it's kind of just buzzed into my head, is it sounds as if it would be absolutely wrong not to give you the training.
(0.3) Silent pause.
Br. Oh! (*Surprise and shocked expression*)
(0.4) Silent pause.
Br. Without the training? Oh! Oh!
An. Do you know what I mean? You know, like come on placement and here's your first client.
Al. No. Oh no. Never, whoever}
Br. No. Phuuuw! }(*And simultaneous laughter from Al and Br*)
An. Well, you know, I can hear and see your reactions to that as a suggestion. Sadly, being in the field, I know it does happen where trainees do go out on placement and do go into placements which do not provide training around the client group.
Br. Well I think it's absolutely crucial to have it.
An. Well as you know, obviously my main interest here is in bereaved clients, the bereaved client population and so for me that's (0.3). Your compliment is <u>lovely</u> to receive; it's also a very strong message that I interpret as, as in the training <u>has</u> to happen.
J. Oh yeah.}
Br. Definitely}
Al. Absolutely}
An. That's, that's important to know. Thank you very much. Thank you very much indeed and I really appreciate your time. I'll now turn the recording off. Oh! I better put my glasses on so I don't push the wrong button!
(*Shared group laughter, from shared experiential knowing of the importance of recordings in psychotherapy training and the fearful horror of key data being 'lost'.)*

Reference: *2010 WBS Focus Group*

APPENDIX 20

WBS FG3 2009

Prior to recording the transcript below, 3 members in the group expressed their wish to give verbalised comments after rather than participate in the recorded session.

Malcolm: I thought the diagrams you gave were very coherent and helped me to understand concepts very well. I really enjoyed the case studies. I enjoyed them and I found them very informative to work through and found them very helpful and priceless. And I enjoyed the experiential.
An: The experiential stuff?
Malcolm: Much to my surprise.
Lewis: I found the diagrams particularly useful. Especially the diagram about the bereavement journey (GED1). And that one (diagram GED2) I found really actually very clear, very sort of, helped me to go through the process in my brain, so I mean that was a definite winner for me.
Malcolm: Could I just add to that, that the continuity of the next one you brought in kind of overlapped with that which is pretty good. – the four sections so I thought that fitted in really well, when tasks of grieving are not met.
An: So they kind of dovetail or are like the two sides of a coin?
Malcolm: Yes.
Sandra: I wanted to say about the diagram, the client's experience of grief (GED2). This is the one that struck me that I liked particularly that worked for me 'cos I kept thinking that this grief process you know, you're going to be in and out. That made sense to me and gave clarity. The thing I was em, uncomfortable with was the em, couldn't get case studies to flow unless they had a name to them and using clt. instead of client and you know, so it took longer to digest the case study and then work on it.
An: So it would have been better to always put in a pseudonym and to always spell out client as a full word?
Sandra: For me, yeah. Cos that's the way my brain works. The other experience was the trauma. That the trauma work, this, you know, understanding the amygdala. That was really powerful for me.
Others: Mm.}
Sandra: It made a lot of sense and it broke up bereavement. It broke the (0.2) When is trauma not trauma and when is grief not trauma.
An: So actually differentiating between the two dimensions of traumatic bereavement; the trauma element and the bereavement?
Sandra: Yeah. 'Cos I would never have thought that until I stepped in here (at WBS) and it would have been enveloped and sucked into the whole experience of bereavement as opposed to trauma specific work.
An: OK. And thinking of the trauma, I'm particularly keen to have your feedback around the nature or the impact of the material upon you. Whether you felt it was too heavy, too raw, or inappropriate. You know, your reaction.
Lewis: I personally didn't actually. Cos em, I felt it has to be raw and powerful to actually get it. If you are going to be working with trauma, you want a little bit of experience of what you're going to be working with. I don't know if they were worst case scenarios, you know I'm sure there's worse but you know it was designed a bit to make you sort of step back but we had the gap in between and I was expecting it to be a little bit worse even from the advance warning you gave us and it wasn't.

An: So it wasn't as bad as you thought it might be? (Also looking round at everyone in the group.)
Lewis: No.} (Others agree simultaneously)
Sandra: I liked the pictures, that sharing, when you put the pictures up cos you know many people don't have an image of a dead person or they have a worse picture than it is. Obviously he died without any facial disfigurement or anything else, that actual bereaved, but em, but that was interesting and I really like the way you said how different cultures deal with it in a different way and how it's acceptable but then how would they have dealt with it if it was a small child or you know somebody who had a loss of limb or something that would have been unable to present in that way. And the cultures, getting into learning about the different cultures I think would be very important when working with a client. Especially with the voodoo and that suicide case.
Malcolm: The other thing I thought was very positive – I thought you were very congruent the way you led it through and built it up to explain what the client was going through.
Robert: Em can I say something? I think em, I appreciate you've worked very hard on all these handouts. I've got a lot to read here, it's a lot of materials and it's been very interesting. Maybe for my own part I found it sometimes a little bit top down delivered. I might have perhaps appreciated a bit more bottom up work if you like but I don't know maybe that just (0.4). We've got some people here that are completely new to it. I don't know maybe they needed it more but overall I've got a lot out of it really.
An: When you say, more bottom up, can you give me an example of that?
Robert: Em, Well I don't know perhaps if you sort of em , if you'd gone about the trauma saying to ask us what do you think would be the main features of trauma or we'd gone into a group and just come up with some ideas.
An: Brainstorming?
Robert: Brainstorming. That's just a thought actually.
An: OK. Does anyone want to respond to that?
Sandra: I don't know quite what you're saying but I've got a sort of a bit of a spin on it which has prompted me to think about what I was going to say last time. Was that your em, when you were dealing with your em diagrams, I felt there was a space there where we could have actually worked with a real person and em built that in. So there's the picture, let's look at this person and you know build that into it sort of so it would make more sense to people who haven't actually experienced a client at all.
An: OK, that's a good suggestion because that's another way to bring in a case study and actually use it during the presentation rather than immediately after. Is there anything else you would like to raise?

No verbal responses. Recording stopped. At final closure, group consensus was:-

- They had all really enjoyed the training
- Got a lot from it, far more than expected
- Understood now what I meant about it being vibrant work
- Were a bit anxious about starting with clients but looking forward to it
- Felt prepared and ready to work with bereaved clients
- Felt it was a pity that they would not be meeting with me again later on

Reference: *WBS Focus Group 2009*

APPENDIC 21

Transcript: Claire Beadon, Luminary Interview
Clinical and Operational Manager of Wandsworth Bereavement Service

Anne: So thank you very much for agreeing to this interview Claire. I'll just start with a very kind of issue around any possible difficulties. Em, so are you aware of what difficulties might have arisen for new counsellors as they've started client work. So almost like immediately following the training and then starting. And it may be that it is or is not connected with the training but it doesn't matter, I'm just sort of wanting, you know, to connect with the starting point for them.

Claire: I think the main difficulty – and I really don't know whether it's to do with the training or whether it's to do with their own anxiety about starting with clients, mostly for the first time ever. But a lot of it, the bit they don't seem to be really clear about, is a lot of the, the kind of admin. And it's about what to do and (pause). It's the procedures, you know if a client DNA's,if a client cancels. Do they contact the client, direct? You know, there's a lot of 'Should I text them?' – So it's around the practical things that somehow doesn't seem to get lodged in their heads.

Anne: Right. That's interesting because whilst I'm sure there's probably quite a lot that doesn't get said or that I don't say in the training because the emphasis is upon the training and it's only six days, there are things around like 'Don't chase a client', Don't, you know if your client DNA's, pick up your mobile phone and say where are you?!'

Claire: Mm. And some of them have said that.

Anne: So what's interesting is how that gets forgotten by some people and [

Claire: Mm. And they do forget. Again, whether the handout – I've no, and I've know, I don't have this as gospel at all. Do they, after the training, do they then just file the handouts?

Anne: Right. OK.

Claire: There's a final kind of an element that makes me wonder if that's what they do. That they don't go back to them. And I don't know, I don't know whether that's, because it's a wodge they just file it, or whether (slight pause) I don't know how split up the handouts are and sectioned if you like. Whether it does come as a kind of and this is the procedure section.

Anne: Yes, and [

Claire: But I do somehow have a feeling that they sort of (pause) or whether it's just in their own head they go 'done that', 'tick it off', 'file the handouts'.

Anne: Mm. I wonder if [

Claire: And a sort of ending. They don't know about the procedure around an ending. They don't know to write the report.

Anne: Which is interesting because that's something that is gone over on the last afternoon. And the, you know the evaluation forms, the ones that you have down in the common room, the tick box form?

Claire: Yeah

Anne: They're actually handed out [

Claire: Those are more likely to get done.

Anne: Right

Claire: It's the written, the written report of the contract – which is the harder bit and it does require some thought.

Anne: Yeah. But, again, that's interesting because one of the things that gets highlighted in that last afternoon, is how, is what **not** to put in the written report. So I'm very particular about ' going over 'do not be diagnostic', 'do not label someone', you know, as, em,

Borderline Personality Disorder 'cos, as, if it does ever go to court, you could be ripped to shreds for saying that. So actually there's quite a lot of emphasis around how to report. You can say ' I experienced the client as ...' so that discussion does take place, so it's very interesting what you're saying.

Claire: They do write their reports with quite a lot of 'I' .

Anne: OK. OK. – Rather than the client though. 'Cos the other thing I suggest is, they say, 'the client reported da, da,da '.

Claire: They don't write it in that way.

Anne: They don't? Interesting!

Claire: It's more about 'I'. (Pause) And I know on one of the headings of the report is 'the work I have done'. Somehow that feels it takes possibly more importance that, than may be required.

Anne: Mmm.

Claire: But that may be to do more with us needing to change the headings.

Anne: I wonder as well [

Claire: Asking them to write it in a different style.

Anne: I wonder as well if that connects with their training. (*Academic course being followed*)

Claire: Could be.

Anne: I wonder what isn't and what is being promoted and encouraged

Claire: Yep.

Anne: in their own training

Claire: about report writing

Anne: about report writing. Actually that's something (0 3). I don't make a link with that 'cos there isn't time.

Claire: I don't either. I've no idea. I've never asked them.

Anne: But I'm wondering if there's anything, there's bound to be an influence, isn't there?

Claire: Yeah. Mm. Their reports do tend to be more personal and less sort of objective. Less 3rd person.

Anne: Right. And that would, for me, as a lecturer really, that makes me think that it's, that they might write it more in the style of a case study. That they might be required to write for their course.

Claire: Ah! Yeah!. That might be. Yeah, that might be it actually. Might well be it.

Anne: So, which is different [

Claire: And it's certainly not in the 3rd person, it's not in the depersonalised.

Anne: No, not the kind of report that would go to court.

Claire: Yeah! Yeah! No, it's not done like that. It probably **is** done more like a case study, thinking about it actually.

Anne: You're smiling. You can resonate with that from your own earlier training?

Claire: Yeah, now you're saying it, now you're saying case study, yes it does. And, possibly, some of our headings like the one about 'the work done is the bit that they pull out.

Anne: So that's something that needs to be highlighted more in the training. Actually there needs to be more discussion around that and the difference, the difference between a case study and a report that would go to court.

Claire: Yup.

Anne: OK. That's, that's useful. And [

Claire: But they certainly do (0.2). I think. (0.5) I can't remember what your question was now.

Anne: Well, it's around difficulties you've found [

Claire: Yeah. And I 'spose, because it is not, I'm not involved in their clinical work primarily, I'm more, my responsibility is the admin side, so that's the bit that I notice although

they do ask me clinical questions, sometimes. Em. I think it is mostly about procedures and then, well obviously it depends on the counsellor and some of them are more anxious than others. And so some of them will be more anxious about the clinical work and (0.4)

Anne: Yes.

Claire: And so the question will often be connected. Perhaps if it is, say suicide and the client DNA's, they may become really anxious about the client's well being, when in fact the client's OK.

Anne: Yes.

Claire: But, but there's another reason either practical or logical why the client's DNA'd.

Anne: But they go to the anxious place that this client is suicidal.

Claire: Mm. Or, or just want to check that they're OK.

Anne: Mm. And they say that to you?

Claire: Yeah, they have done.

Anne: What do you say?

Claire: I say 'Don't ring them'. Write to them. No, don't ring them, especially during the sesson time. No. And write to them.

Anne: So there's a , you know working with a suicidal client, IS anxiety provoking. Em, [

Claire: Or a client who has been bereaved by suicide, whether or not they are suicidal.

Anne: Suicidal themselves?

Claire: Suicidal themselves. I mean if they are suicidal themselves, then it is a different story.

Anne: Yes.

Claire: If the death has been by suicide, then they can get, initially, they're more likely to, em, become less anxious once they've had more experience.

Anne: So maybe there's this, anxiety around the word suicide for new trainee counsellors?

(0.6) Silent pause.

Claire: Eh , I don't know is the answer to that. I don't know.

Anne: No, no. You know, I mean, I'm just wondering again. My mind's gone back to the sort of the training and I'm thinking well, of course, some of the case studies, em are on suicide deaths.

Claire: Mm. Which I think is absolutely right because they need to be made aware of the complexity of the work here.

Anne: Mmm.

Claire: And, I mean that's the good, that's the brilliant bit about the training. And almost all counsellors when they leave and I do their exit interview, the one thing they **all** talk about, is how great the training was. How great you are. How great the training is.

Anne: Mm! Mm! Oh!

Claire: But they all say it. It's the one constant. All the exit interviews say how great that initial training was.

Anne: Mm. And is that unprompted by you?

Claire: Yeah, yeah. It's really when I say 'So what are the good bits. I want some feedback on your time at WBS. What would you say about WBS as a placement organisation? And they almost all go straight to 'the training was fantastic'.

Anne: Right. Right.

Claire: So they obviously (0.3) enjoy it.

Anne: Mm.

Claire: They find it interesting, they find it helpful. I think they find it very engaging. And your style they find engaging.

Anne: OK. That's good to hear.

Claire: Mm. But I, you know, I don't know whether, whether it's sort of emotional overload in terms of what they then forget.
Anne: Yes. That's a good point.
Claire: I don't know. There is stuff they then forget.
Anne: Mm. And the stuff they tend to forget, is that more the pragmatic, practical stuff?
Claire: Well I think so.
Anne: So I wonder if the point you're making there which seems really important is, is there an emotional overload?
Claire: Mm.
Anne: that is around the nature of the work so that they're over sensated.
Claire: Yeah.
Anne: That's where I'm going to with this [
Claire: Well I wonder.
Anne: If they're over sensated, coming back to your original difficulties that you've highlighted, if those pragmatic, factual, organisational things just go out the window.
Claire: Probably.
Anne: Right.
Claire: But the stuff, they do say, there's stuff they didn't hear, they didn't know and when I ask you about it, you say, well I've covered that.
Anne: Mm. That's right. Yeah.
Claire: And over the years it has been a theme. It's come up so many times. I mean, we've talked about it.
Anne: Yes. Yes
Claire: And they say, or they often say ' I haven't got a handout'.
Anne: Yes. Yeah. And yet [
Claire: And yet, and yet they've, you've given it to them.
Anne: Yeah and some people have .. I think I remember on one occasion at least in the past where someone in the same group, did have, someone in the same training group did have the handout and someone else had said to you they didn't, they never got one. But I think that was one occasion a couple of years back.
Claire: Yeah. So I'm not quite sure what it is they (0.4)
Anne: Well maybe it's what you said. You were saying, you were questioning earlier whether they just file it away and it's sort of 'that's done and dusted now', 'I've done the training. I'll be coming in next week for my clients'. Maybe they don't register that bit of the conversation and they never go back to the handout.
Claire: Yeah.
Anne: So they never have actually read the handout.
Claire: Well that makes sense.
Anne: So their experience is that they haven't got one. Mm!
Claire: That's what I wonder about whether it's sectioned. So that it's kind of with a divider, a kind of
Anne: Mm. Well I think it's interesting because, em, I usually do those, the report writing stuff and the pragmatic stuff, as partly as a wind down and from the case study work, the emotional stuff and as a wind down and an evaluation of the 6 days in that last afternoon. But, I'm wondering if, because it's always delivered in two blocks, two three day blocks, I'm wondering if maybe it's about re-organising how that's done. Give them that paperwork to take away with them at the end of day three and then have a discussion when they come back.
Claire: Right. Maybe.
Anne: So they are required to read it.

Claire: Yes. That makes (pause). 'Cos they may not read it. They may not think they've got it 'cos they haven't read it.

Anne: Yes. 'Cos they do get handouts to read but it's usually in the form of maybe something to do with theory like 'Shame', or an article on shame or something like that, or 'sudden and unexpected death' handout. They get handouts but I'm wondering if I actually re-organise it a little bit.

Claire: Mm. Mm. 'Cos even this time round, when you didn't do the organisational stuff 'cos you substituted the couples work, and so I then wrote this memo, that they've now all got, I think which is about 3 or 4 pages about organisational stuff – what they have to do. You see, I'm still not absolutely certain they've read all that either.

Anne: No. Right.

Claire: So, because, there are a couple of them who kind of go so what do I do now? You know, particularly. It's more about clients DNAing or cancelling. And I suppose it's about one of the other things consistently coming up but I don't think it's anything to do with you or the training, is what we do about missed sessions. Do we count them or not count them? And there are a number of counsellors who, when I look at their attendance sheets, have not counted any cancelled sessions.

Anne: Their client attendance sheets?

Claire: Yeah.

Anne: Like the stats. The monthly stats.

Claire: Yeah, the monthly stats. And there are some who get it and some who don't get it. Is it because they don't' get it because they don't want to, or is it because they think it's mean and unfair to count a missed session?

Anne: Mm.

Claire: But it's written out in that memo. It's very clear in that memo what you do and what counts. That basically, almost everything does count but some of them still don't get it.

Anne: Mm. Have you- just a thought that's going through my head as we're speaking-is, can you make any connection with the particular counsellor's theoretical orientation?

Claire: One in particular is Gestalt. Well one called Re-Vision. There are certainly counsellors who adhere to the 12 sessions and who think clients would benefit from longer work and who ask for an extension if the client needs it but that is a different issue from not understanding what a missed session is and not getting it. I'm not sure whether it's, I haven't thought about it enough in terms of whether it's related to their training. But it's the one thing I spend more time trying to get them to understand.

Anne: Mm. I wonder if, em, the thought that I've got is whether at the end of the training, they're given a final sheet, condensed into just one A4 sheet, em. with, em , a kind of tick box thing, and they're asked to go through it. So it will list for example, every handout that goes with the training, organisational policies, so adding the suicide policy, you know, etc. etc. Em, things you want them to read such as you put in the memo to them, key aspects about organisational working, including, you know, the information on supervision and attendance. The BACP code of ethics and so on and that thy're actually asked to go through this and tick [

Claire: What they've got?

Anne: Yeah. Tick that they actually have each of those handouts, each of those bits of paper. And that could they hand that to their supervisor when they first, in their first supervision session. And their supervisor leaves it for you and it goes in their personnel file (with application, CRB check).

Claire: Yep. Yep.

Anne: Maybe with something like that. And it's not to be [

Claire: Making them, making them look at stuff.

Anne: Well it is but it's also for their benefit. Because, you know, it's a two way thing, then. It's also making sure they have got each piece of paper. So if for some reason, I or anyone else, you know had forgotten to give them an article on suicide or 'continuing bonds', or whatever, they could actually say, ' no ,this one I haven't had'.
Claire: Yes.
Anne: So actually it is a check. It's a check list.
Claire: And I'm wondering if, if in, whether that, even starting, they get given that checklist at the beginning of training.
Anne: Oh! OK.
Claire: And, and, and they fill it in as they go along.
Anne: That's a good idea. It's better. It's a better idea, Claire.
Claire: Then they can fill it in that day or later.
Anne: Yeah.
Claire: Then they say yes, I got that, got that, got that and they can bring it back for the subsequent weekend.
Anne: That's good.
Claire: And then, then they give it to their supervisor and on to me.
Anne: Yes, that's good.
Claire: Then they know and we know
Anne: And the supervisor knows
Claire: Yes, WBS knows. We know what they've got.
Anne: Yes. That's a better idea. It's more [
Claire: Actually it could be more in their heads, it's more sectioned.
Anne: That would work well and it's a good idea of yours to have it at the beginning cos actually I know, I can imagine how half of them at least, would do it at 1 o' clock, when we break. They'd do it for what they got in the morning and then it's done.
Claire: But others might not do it till the last afternoon and then they don't know what they've got 'cos they've left half the stuff at home.
Anne: So that might be a very useful way of consolidating quite a few things, um.
Claire: And it might make them. I know that if I go to Conference and I come back with a pack, do I go back to it? Well, actually, probably not.
Anne: No. I know. I agree.
Claire: Em. So it might be a way of getting them to read through.
Anne: So it would be helpful to them, wouldn't it, em, really [
Claire: Somehow finding a way to get them to log what they've got. You know, mentally log it.
Anne: And I, I'm really, em, aware of what's going on for me at the moment as we're talking, as well is, because this about the admin, that is very much cognitive stuff. I'm thinking about the stuff I deliver as case study material, some of which as you well know, is traumatic and I'm thinking here of the parallel with the training content. How the admin stuff just doesn't get processed, doesn't go in.
Claire: Kind of traumatising.
Anne: It's well, hopefully, they're not actually traumatised but it's where the focus and emotion is.
Claire: In the trauma work?
Anne: In the trauma work but even if it's not trauma work, it'll be connected with the feeling, the visceral experiences of a bereavement. Even if it's not a traumatic death or a traumatic bereavement. Actually what's in the case study, even the facts about it, are something of a visceral nature because of the circumstances as it's described, of the death and the meaning of loss to that person. So, this is making more sense.

Claire: There's something about trauma that they are kind of over-sensated [
Anne: a lot of emotive material
Claire: yeah and there's some trauma response as there would be in real trauma, to the case studies but they need it because that's [
Anne: the work
Claire: the work. If they didn't have it, then we'd have, it would be much harder.
Anne: Well, you wouldn't be able to allocate, would you?
Claire: No and they just wouldn't be able to manage because they've got to be exposed in the training to what the real work is gonna be and whilst it may be a shock in the training, if they don't have the shock of the training and haven't been through that experience, then being face to face with a client, it's going to go all horribly wrong because they haven't been exposed to it. If the first experience they have is in a room with a client, they'll be even more anxious and traumatised.
Anne: Yeah.
Claire: So they do need it.
Anne: Yes, but it's interesting that, that, it, that all that energy is there, is in the right brain the feeling, sensation side and the cognitive stuff, isn't being processed in the same way. It's not going in, not being processed.
Claire: OK. Yes. I don't know enough about the neurological bit.
Anne: It's just that, em, where all their energy is in the material which is , yeah, em, so when they're saying ididn't get that or, no I didn't get, you know because they probably haven't gone back and read through the pack afterwards, their actual experience is they didn't get it. And they don't remember that. It didn't happen 'cos what they remember is this other stuff around the cases.
Claire: Mm. Mm. OK. That is probably it. Probably it.
Anne: So it makes even more sense to do the checklist because it is a way of connecting. It is very much a way of connecting the feelings stuff and the being exposed to stuff with the cognitive side. Mm. That's really useful. Really useful.
Claire: Yes, it is like a bereavement. They don't remember stuff. Their concentration goes.
Anne: Yes.
Claire: I mean, they are concentrating on the piece
Anne: Of course, 'cos they work very hard.
Claire: But they're, all those words on the first sheet of the handout, at assessment, you know, kind of
Anne: That's what's happening.
Claire: That's what's happening. And it is like having a response to a trauma like the client is.
Anne: Mm. Yeah. Makes a lot of sense. And, of course, for quite a few of the trainees, it will be the first time they've been exposed to such awful material.
Claire: Absolutely, but again, I haven't thought about it enough in terms of which counsellors are less able to recall the practical stuff.
Anne: Mm. Mm.
Claire: Is that, is there, is that the client (meant counsellor) who's had any less experience of trauma, or less robust themselves. I don't know if it's them who find it hard, or not.
Anne: Mm. Or something to do with their own personality. Like someone who has a very organised personality type. You know, the em, is very, em, perhaps even a little bit more on the obsessive side where everything is kept in order and neat and filed away and so on. You know, would that person be more likely to em, have read everything and noted everything, or not.
Claire: Yeah. I don't know.

Anne: It's, it's, 'cos there are. You know you could naturally, obviously in the training group, different personalities do emerge and in a way, that's, that's completely, that's a piece of research waiting to happen as well.

Claire: 'Cos I haven't really thought about it until today. Because there's such a range of counsellors, you know having different lengths of time they've been here. I don't separate it out in my head and think where's this issue coming from. You know, from a newly trained counsellor, from a counsellor whose been here longer, it's this kind of person. I need them to do what they need to do. Yeah, I don't separate it out in my head. I just want it done.

Anne: This is where people have to be able to work within an organisational context. That's an interesting issue because there have been a couple of people who have done the training, who were great in the training and contributed really well and when they got into the space, of having to work within the organisational context, it's gone haywire. Yet they stood out to me 'cos they engaged so well during the training.

Claire: Yes. I think that's, those are the only difficulties I'm aware of.

Anne: Mm. And I know you're not a supervisor to the counsellors but I just wonder if you're aware of any gaps in the training. What's not delivered, what needs to be added, or needs to be taken out. Anything around that.

Claire: I don't think I know that. The only thing I'm exposed to is the admin stuff. Most of the stuff they ask me, is, is stuff that they should take to their supervisor. Is a clinical issue that's just arisen and I'm here so they'll ask me. And I would say it's a kind of issue that would need to be taken to supervision rather than it being a recurring theme. It is, this has just happened, this has taken place, what do I do now? They're one off issues. I can't think of anything that keeps on coming back as 'oh! They don't know that' about bereavement, loss. I can't think of anything that I keep on seeing.

Anne: OK, so although it's an issue they would take to supervision, it's not as if it's creating some kind of theme that's being triggered for you around something to do with theory around grief or loss or whatever. Their information, or knowledge rather, knowledge that they haven't got.

Claire: No. No. I wouldn't say so. They're more one off issues. They are trainees. Em and it just needs to be discussed. I don't think there's any theme in there about the actual content of bereavement work that is lacking.

Anne: OK, that's useful. I'm just going to have a look at my prompts. One of the things is what would you like to see more of or less of but really in a way [

Claire: That's more the supervisors.

Anne: It's the same thing really and what you would like to see more of, we've discussed around the admin.

Claire: Yeah.

Anne: And that checklist and that would be that, wouldn't it?

Claire: Yeah. That's it really.

Anne: You've actually answered some of the things I've got down without me asking the question, you've answered them which is great.

Anne: I 'spose, coming back to the supervisors, em, are there any, cos I know you meet with the team of supervisors, obviously, is there any difficulty or feedback that you feel is relevant for me to know?

Claire: Haven't written up the minutes of last week's meeting. Emmm. I think, I mean the last week's meeting there were the 2 new supervisors, so they were and there was Sylvia and Mandy couldn't come 'cos of the snow and I spoke to her and actually, they were really asking practical things. I mean the 2 new ones understandably. It was more about what happens when they don't attend? Em and it sort of ended up being well counsellors

should attend unless they're on holiday or end up being sick. Well that's the bottom line of it. That's it, nothing else (0.3)

Anne: is acceptable

Claire: is acceptable. You know, major family emergencies, fair enough. So it was more practical stuff rather than being anything else. We touched on training and the calibre. Well, there was something around the new group and the old group but that was Angela saying well I call one group my experienced group and the other the new group. Well, that's what they are. I mean that's what they are and she's identified that.

Anne: Yes. So that comes across clearly to the supervisor which is great.

Claire: Yes, it was very clear to her. She got this. When did she come? She came September so she did get one group straight out of training and one group who have been here over a year.

Anne: interesting experience for her I would think.

Claire: Yes but she can identify between them very clearly so I suppose it does show how, almost how quickly, they get this tag of experienced counsellor.

Anne: 'Cos it flags that up doesn't it? It flags up how they do really acquire their knowledge and skills, their competency in bereavement work through the client work. I mean it's an obvious thing but that's empirical evidence that's evidence there.

Claire: So from a 12 month period of practice, she can distinguish very clearly between the new ones who are much more anxious

Anne: Yes, yes and I imagine the way in which individual supervisees present their client work, what they bring and how they present it.

Claire: Yes. So, again, it was more about. And one of her supervisees had a client who was semi-suicidal. Had suicidal thoughts but not actively suicidal and that counsellor became quite anxious about that client being offered an extension and in the end when that was discussed in supervision, and I heard this from Angela rather than the counsellor, that it was decided not to offer an extension. That this client was in fact OK but the counsellor became very anxious that the client wasn't OK. But I don't think that's anything to do with the training. I think it was about being there with the client who was very distressed but actually it became manageable. I think, again, this is a practical organisational issue and the new ones do get concerned about the 12 sessions.

Anne: Yes, yes.

Claire: But the evidence again is that we get 1% of clients who come back.

Anne: I was going to ask you about that. I've got attrition as a question.

Claire: It about 2 clients a year who represent.

Anne: For the same bereavement?

Claire: For the same bereavement. And everybody's offered that. Everybody is offered to come back if that's what they feel they need to do and we get one or two a year. Even the experienced ones who feel that 12 sessions is not enough. I mean it may be that clients who aren't fairing particularly well, aren't fairing so badly that they don't particularly want to come back.

Anne: Yes. And that's an unknown.

Claire: Yes, it is an unknown. We don't know.

Anne: And I guess you don't know if they've gone elsewhere.

Claire: No. No. Some clients we do identify that they need to go elsewhere. That it's not bereavement work any longer.

Anne: Yes.

Claire: That they might need longer term psychotherapy

Anne: Mm. And that's always been the case.

Claire: And that's always been the case and always will be.

Anne: Yeah and that is something that is discussed in training, that this is a bereavement service
Claire: Oh! OK.
Anne: and there will come a time for several clients where the bereavement was done but actually there could still be a great deal of psychotherapeutic benefit.
Claire: And I think there is. Still there's a great deal of anxiety about the 12 sessions amongst the new counsellors and then there's more the established ones who think well 12 sessions isn't enough and they would benefit from more. And maybe they would. There's no evidence from the supervisors and hasn't been since, you know it's five years now since we've had the 12 sessions. It started 5 years ago and there's no evidence amongst the supervisors that 12 sessions doesn't work. In fact, almost every supervisors meeting we have, they go 'stick to 12 sessions'. It's OK.
Anne: 'Cos you check that out with them, every time you meet.
Claire: yeah, yeah. It's kind of 'how is the 12 session? And because there is that potential for an extension (pause)
Anne: Yes, having an extension potential there in discussion with the supervisor, is a way of ensuring that no client is being turned away at risk.
Claire: Yes, a subsequent, second bereavement.
Anne: I remember you saying some time ago and actually I think it came through the supervisors that they felt the client work, the clients themselves in the therapeutic work, became more focused, very often.
Claire: Yes, I think it has come from the supervisors. But the clients do work very hard. My clients work very hard.
Anne: Yes, of course because you have your own case load.
Claire: But I think there is a benefit from that time limited contract. Rather than it being more fluid. And I think DNA's have gone down.
Anne: Ah!
Claire: We have got the figures. And it was my personal attendance rate that was 85% cos I do keep it and it's been consistent in the 5 years I've been here, 85 % attendance.
Anne: Is that every year?
Claire: Yeah. It's still over the 5 years, it's continually 85%
Anne: That's interesting isn't it? The consistency of the percentage over 5 years. I think that's really interesting.
Claire: Yes. And I'm fairly certain that when Bridget did it, it came out pretty similar.
Anne: For the sheets, for the counselling team?
Claire: Yeah.
Anne: Oh that's quite significant.
Claire: It's in that ball park. 'Cos I remember thinking when she did it, it was like mine.
Anne: So there is a real consistency there.
Claire: So I think it does focus them, the clients.
Anne: Yeah, definitely, cos that is a good DNA rate really.
Claire: Well that's the combined DNA and cancellation.
Anne: Oh! And cancellations? With notification as well so it's not just the DNA rate. So the DNA rate will be a lot lower.
Claire: Yep. (0.5)
Claire: I can't remember how many DNA'd their assessment. So for assessment we've got DNA and cancellation, and no longer required, or did not respond.
Anne: I think that's interesting around assessment, isn't it, because, in a way, a DNA for assessment becomes part of the assessment.
Claire: Yes.

Anne: How are we doing for time? Nearly up to an hour aren't we. OK. Mm. I wondered, a little bit about orientation, whether there have been any issues that you've been aware of, or supervisors, for you around counsellor's theoretical orientation that might have been a kind of difficulty, and it may or may not be.

Claire: No. I don't think. The bulk of the counsellor's are humanistic or integrative and that's where they're coming from.

Anne: And you feel that in your experience from being here for five years that that works well for bereaved clients?

Claire: Yeah. I think it is actually.

Anne: Mm.

Claire: And I know that you said with Bridget with her psychodynamic (pause) and I think she is increasingly writing her assessments up in a psychodynamic way.

Anne: Mm. Mm.

Claire: That may not be so understandable or accessible to a non psychodynamic counsellor. I think that's an issue about how she's writing them.

Anne: Yeah. I've noticed in the training that, em, some of the trainees despite being new to the field, they have picked up, em, either specific points they've queried or didn't like the sound of, or didn't like the interpretation that was being put on the assessment form

Claire: Right.

Anne: and/or that some of them flagged it up as being 'this sounds very psychodynamic to me'.

Claire: Yeah

Anne: So it depends on how attuned or astute they are to different orientations within their own training, where they are at the stage of their own training. And so for some people it smacks them in the face as psychodynamic – and they say that as I never do. You know, I never put that out there, um but it always comes up. So either in the form of 'this is', or

Claire: What does that mean?

Anne: You know, 'I don't like the way '. Clearly that is with the very humanistically trained counsellor. So it's fascinating.

Claire: Cos I don't know what a humanistically trained counsellor is taught.

Anne: No. I guess basically, much less emphasis upon interpretation and also much less emphasis upon, let's say, the em, more sort of genogram kind of information.

Claire: More information on that?

Anne: Less. So a very humanistic person would pick upon a lot, if there's a lot of emphasis around the sort of, the earlier family, the early years. And that's not to say it doesn't play a part in the counselling because of course it does, but it's about where it figures. Is it figural or is it ground, where it's located within the assessment. How prominent is it? It's not that it's irrelevant but it's

Claire: It's how prominent it is.

Anne: And very often on the psychodynamic assessment, it's there (claps hands together).

Claire: But I think humanistic and integrative are absolutely fine. Em, that's about it at the moment. Oh and existential and psychodynamic.

Anne: So there's no difficulties that

Claire: No.

Anne: Which is great isn't it, cos you do have a variety [

Claire: It's changed now that we've upt the anti and require people to be on a degree course, well a couple of them aren't but are on an accredited course, that has changed the calibre.

Anne: Yes. And most of them are on a Masters, or the lead to.

Claire: Mm and there are a couple of accredited (*Diploma*) courses.
Anne: And how do you find that?
Claire: It's fine. Because I think they're on an accredited course. It's the calibre and that makes all the difference. So it's not necessarily about theoretical orientation.
Anne: And really what you're saying there, I mean the flip side of the coin is that courses which are not accredited in perhaps smaller type of colleges or institutions, the calibre of training is not up to the bereavement work.
Claire: Yeah. They're not given a sufficiently good grounding in theoretical work and theoretical principles. So it's about the course and the level of the theoretical training and not the orientation.
Anne: And that's very important, isn't it? Especially as the training they get here, is specifically on bereavement work. It's not about either theoretical orientation as in professional knowledge and nor is it on skills competency, development of skills. I mean the 6 day training is absolutely focused on the experience of the bereaved client and the needs of the bereaved client and is actually transtheoretical.
Claire: Exactly. Yes.
Anne: It's been designed to be that.
Claire: And they get it. They do get it.
Anne: And you feel that that works.
Claire: Yes it does. They do get it.
Anne: Cos it is stated on the first day, the first coming together so to speak at the usual circle of introductions, one of the things I do say, is this is not about specific theoretical orientation and developing your skills and competency in your training modality. It's a 6- day intensive training in bereavement and its complexities and is for you to integrate that into your own approach.
Claire: But it is about grief theory.
Anne: Absolutely.
Claire: So it's about theory but not where they're coming from theory.
Anne: No. Not about therapeutic orientation.
Claire: But it is about grief theory and they do get it.
Anne: And the idea of the programme is that it is applicable across the board and that has included counselling psychologists and so on who do the CBT, psychodynamic and person-centred, these three theoretical orientations within that.
Claire: Mm
Anne: OK. I'm aware that we've done an hour and so I just want to say is there anything else that you would like to add, Claire?
Claire: No, I don't think there is. Is there anything else you want to ask?
Anne: Em, no. I think it would be good if I could gather up some stats but we've talked about that.
Claire: Yeah, sure.
Anne: And I really appreciate your time now and all that you've said. And I'm really excited about it. There's some smashing stuff in there and some real stuff I hadn't made connections with until our discussion now.
Claire: Yeah well I did too.
Anne: I've had a few aha moments!
Claire: Well I hadn't sat and thought about it before.
Anne: No? Very spontaneous. That's nice.
Claire: I mean, some of it I'd thought about cos they're the problems but the actual kind of (0.11)

Anne: Well hopefully some good stuff will come out of it for WBS as well and for the training as that's the purpose of it to continually improve, to build on. Well thank you very much Claire.

Themes:
Administration and procedures not assimilated by participants
12 session contracts
Theoretical

Reference: Transcript of Interview with WBS Operational Manager, 2010

APPENDIX 22

WBS Validity Questionnaire 2017: 7 Years Post WBS Training

Please respond to the following sections according to your experience of the WBS bereavement counselling training and your experience as a professional practitioner working with bereaved people.

1. Training content:

1a) If there were any specific materials which you found particularly helpful to you when you started to work with bereaved people, please identify these.

Learning about the grief work models helped me be more comfortable with my clients as well as more understanding and therefore more at ease with the many conflicting emotions they experienced. I found the Dual Process Model of Loss particularly helpful when I started to work with bereaved clients. Learning about this model enabled to meet my clients where they were – not necessarily putting them in a "phase" or "task" box and adopt a more flexible stance with them as they journeyed through the grief work.

1b) Please also identify any content which you consider to have been missing from the training and which would have been beneficial to include.

In hindsight, it would have been helpful to have more in-depth material regarding the psychotic grief process. Although it was briefly covered during the training, I believe I would have been better prepared in my interventions had I been able to identify what was going on for one particular client during my training at WBS.

1c) Please comment upon the materials presented during the training programme in relation to your clients' lived experiences of loss and grief.

With the exception of psychotic grief process, I have not encountered a case that was not comprehensively covered in my training. Two of my female clients at WBS lost their sons through violent deaths - suicide and murder. Another at WBS was a war refugee and lost most of his family members due to political conflicts. One recent client in my private practice lost both parents as well as two of four siblings in an accident. Others lost children including unborn babies. The impact of these scenarios on the survivors was covered as part of my training and

the theoretical knowledge I received helped me develop my confidence as a therapist.

2. Clinical practice:

Please indicate if you have ever encountered any of the following when working with bereaved clients, whether WBS or another client group including within any private practice work.

A) A client(s) who has experienced loss or death as traumatic - please add any additional comments/ observations/ recommendations you consider to be significant for therapeutic practice and knowledge in working with traumatic bereavement.

One of my young clients in his 20's lost his father, mother and two younger siblings in an accident. Two older sisters, already married with children, were not in the plane at the time of death. They both received counselling and one their counsellors contacted me through my website to ask if I thought I could work with the young bereaved man. I agreed and I started to see my client barely six months following the tragedy. Thanks to my training, I was aware that it might be too early. I took my client to supervision and my suspicion that he might be in denial was confirmed. I was aware that anger is a major emotion in grief work; however, my client allowed his anger to surface only briefly at our fourth session and subsequently disowned it. According to the result of the inquest that came up about that time, his father, who was piloting the aircraft, was found at fault therefore responsible for the accident. At this point, my client chose to end therapy. We had only six sessions and little progress was made. My client showed his grief and sadness at the second session and glimmers of his anger at the fourth session. My training helped me accept that it was not my incompetence that brought an end to our sessions, rather I believe the impact of the accident was too big and too horrible for my client to begin the grieving process at this point.

B) A bereaved client(s) with a psychotic process - please outline how the psychosis manifested in the client and any additional significant information/ experiential knowledge gained re working with a psychotic grief process.

The client whom I saw for 24 sessions while training at WBS lost her mother and it sounds as if she had a symbiotic relationship with her. My client was in her mid 50's at the time. Mother and daughter slept in the same room on twin beds close together. They had always lived together and did almost everything together. When they left Iran for the UK when the Shah was thrown over, my client was in her late teens. From what my client told me, it became clear that her mother had control over her all her life – my client was not allowed to date or have a social life after work, consequently she ended up devoting her life to her mother. After the burial, my client not only had morbid thoughts like going to the cemetery at night and open the coffin to see her mother, but developed hearing hallucinations, which I believe were related to psychotic disorders. Night after night she could clearly hear her mother "breathing and grunting" in her sleep exactly as she had done when alive. My client said she believed her mother was in the room and alive when she heard the noises. In my opinion, this was different from seeing her in the shape of a butterfly or a leaf or sense her presence in the kitchen. Although these "signs" were covered in my training, I believe it would have been helpful to know more about psychotic grief process as this would have helped me normalize in my head what was going on for her.

C) A client(s) whose grief process has continued beyond two years after the bereavement - please add any additional information/experiential knowledge/ practitioner thoughts you have in relation to this.

This week, I started with a 28 years old male client – let's call him Simon - who has an MA in neuro science and works as a Clinical Psychologist assistant. His reason for seeing me is stress related, he said. He talked about his professional dilemma and his relationship to his 24 years old girl friend who is also a Clinical Psychologist. I noticed somewhat surreptitious anger in his narrative. His anger came to the surface as we started to explore his feelings. Perhaps because of his studies, the nature of his work, and his readiness to understand what's going on for him, he was keen on exploring and understanding his emotions. As his narrative unfolded, he talked about the death of his friend – let's call him Peter - which happened two and half years ago and whom he had known for over 10 years. After several unsuccessful attempts to take his own life, Peter hung himself. Simon took care of the funeral arrangements and the service, and was present when the coffin was lowered into the ground. Simon thought that he was partly responsible for the death of his friend, that he should have seen the signs. Only after Peter's death did Simon learn that Peter had been adopted and had

been battling with ongoing depression. His best friend had kept secrets from him. At the time of the death, Simon made the solemn wow in front of Peter's adoptive parents to devote his life to work with people suffering from mental health problems. It's worth noting that six months after his friend's death, Simon had four NHS telephone bereavement sessions and he said they helped at the time.

I believe I'm working with unresolved grief. First, there seems to be a lot of anger in Simon, which he attributes to his perfectionism and his tendency to compare himself negatively to others, but I can't help wondering if he might feel betrayed by his friend who kept so much hidden from him. Second, part of him wonders if he could have done something to prevent Peter's suicide. He knows this is irrational but his heart says otherwise. Third, he feels he would be betraying his friend if he does not continue his studies further towards a doctorate, although this is financially impossible.

Although we had only one session so far, my feeling is that, unless we work toward closure, it will be difficult for Simon to live his life fully according to his own desires.

D) A client(s) who has/had Tinnitus which developed following a bereavement - please add any further information/ observations/ comments which are significant.

I had the opportunity to share my own experience directly with you Anne during my training in 2010 when the subject of Tinnitus was approached. I first developed Tinnitus in 1980 following a move involving several losses. I saw my GP and a specialist, and both were unable to find any physiological explanations for my condition. The Tinnitus lessened over the years but never disappeared. Interestingly, it worsened again shortly after the death of my father in 2013. It was after the training, so I was not able to share this with you. My GP ordered a CT scan and, once again, nothing abnormal was found. I still have it and have learned to live with it. I haven't had the experience of working with clients who mentioned suffering from Tinnitus as a result of bereavement.

E) A client(s) who has/ had IBS which developed following a bereavement – please add any further information/ observations/ comments which are significant.

Some of my clients suffer from IBS, but their condition seems to be related to anxiety rather than the result of a bereavement.

F) Please add any further experiential knowledge you have gained in relation to clients' loss and grief and the impact of bereavement which has not been covered above.

This might not answer the question, but I would like to add that although my training covered grief work as it relates to death, I find in my practice that the bereavement process is relevant to all kinds of losses like separation and divorce, children leaving "the nest", moving away from family and friends for work or political reasons, loss of purpose and more. When this happens, I often recognize manifestations of grief in my clients and I using the knowledge I gained in my training.

3. Since the WBS bereavement training:

3a) Have any of the materials remained useful to you? If so, please indicate:

I still have all my notes. I no longer refer to them all that much but I sometimes use them to "revise", particularly when working with complicated grief.

3b) Please comment on any influencing factors/ sources which inform your therapeutic approach when working with bereaved people (e.g. theory/ literary sources/ personal experience/practice - based experience).

I work with clients presenting with a wide range of problems and bereavement is a small part of my practice. My therapeutic approach when working with bereft clients is mostly humanistic and person-centred. I believed this is the result of my university training, the theoretical orientation of my supervisors at WBS and my clinical experience. An empathic stance goes a long way toward relieving loneliness and, in my opinion, sharing the pain helps make it a little more bearable. My own process following the death of my father with whom I was close helps me understand that grief can linger on and on. It also helps me understand that anger is never far beneath the surface.

4. Anything you may wish to add:

As I reflect on my practice, when bereavement comes up, I find that I slow down, kind of like going from fourth gear to first gear. I put asides my usual inner thoughts about what approach would benefit my client the most, be it psychodynamic, solution-focused, CBT etc… I breathe, I slow down, I ground myself and my goal is TO BE alongside them.

I was very pleased with the training I received. Thank you Anne!

And finally, please would you indicate:

Your theoretical training/ orientation: Integrative

How you identify yourself as a practitioner: Humanistic/Integrative

The year in which you completed the WBS training programme: 2010

Thank you for your time and consideration which are much appreciated in completing this Questionnaire.

Reference: Received March 2017

APPENDIX 23

WBS Validity Questionnaire 2017: 5 Years Post WBS Training

Please respond to the following sections according to your experience of the WBS bereavement counselling training and your experience as a professional practitioner working with bereaved people.

1. Training content:

1a) If there were any specific materials which you found particularly helpful to you when you started to work with bereaved people, please identify these.

I have valued my A4 resource file from day 1. This was thoughtfully sectioned, including practicalities with contact details; assessment process to allocation; mandatory supervision arrangements; client attendance sheets; onward referral sources as well as client cases. I also valued the evidenced-based traumatology information, including creatively adapted colourful Figures that supported my learning: neurobiology of trauma; “drop-off” points adapting to bereavement; risk factors for complicated traumatic bereavement. This helpfully incorporated aspects of the trainer's own original research, along with thinking about the impact of death from socio-political-cultural perspectives and spiritual matters.

The lived experience of a NHS (band 4) bereavement co-ordinator, which supported me reflecting more upon the role of staff who interface with bereaved people. It thus raised my awareness of the schism between the direct responsibility of such staff and their non-clinical grading compared with other staff. I also valued reflecting upon insights of a police FLO working with bereavement and a transcript that emerged from the horror of 9/11.

The anonymised case studies were very helpful and supported my reflection upon the lived experiences of past clients who had attended WBS. This helped me appreciate and feel more prepared to work with a range of traumatic bereavement clinical presentations, whilst reflecting further in dyads gave opportunities for reflection in action as a counsellor to feedback my experiences to share with our group.

Reference list- has been an invaluable resource.

1b) Please also identify any content which you consider to have been missing from the training and which would have been beneficial to include.

Whilst I'd have valued further training days later on at WBS to support work with bereaved children and adolescence, I too know that this would have been too much to cover and undertake clinically starting out in this speciality.

1c) Please comment upon the materials presented during the training programme in relation to your clients' lived experiences of loss and grief.

The case-study materials, in my WBS training, and model of grief and loss that supports developing a new bond with the deceased I have found highly applicable to my clients' lived experiences of traumatic grief and loss. Whilst this does not negate that their experiences are unique to them, it often helps to both validate and normalise what has felt overwhelmingly shocking, frightening and isolating for most of them.

Reflecting in our group with our facilitator was excellent.

2. Clinical practice:

Please indicate if you have ever encountered any of the following when working with bereaved clients, whether WBS or another client group including within any private practice work.

A) A client(s) who has experienced loss or death as traumatic - please add any additional comments/ observations/ recommendations you consider to be significant for therapeutic practice and knowledge in working with traumatic bereavement. sorry if some of this is wonky!

WBS - working with bereaved clients who have experienced traumatic suicide or a murder of a family member- including finding the body; receiving the news. **Feeling violated when the suicide of their family or friend was "made into a crime scene" ; not enough time with the body- feeling horror seeing removal of the body; isolation and loss before an inquest and the traumatic impact of attending the latter.**

The themes from such clients above, are often linked too with the impact from the public nature of an inquest enquiry with media exposure about the death. This **directly contributes further to their bereavement trauma and needs to change.**

WBS- traumatic bereavement following death of a pet. I don't think emergency vet services in London are very geared-up to supporting newly bereaved. My client had a history of enmeshed relationships and class A drug abuse. She coped with her pet loss by wearing clothes, dying her hair, buying leather the same colour, phone cover, handbag, and painting her nails the same colour as her dead dog! Part of my work was to help her reflect upon how **this both supported her and was part of a pattern of over-identifying that made it hard now for her to adapt to her loss.** So raising awareness the impact of pet death is very important!

WBS- **Traumatic impact of secondary hospital care** when often bereaved people feel their informational needs, care and treatment of their now dead family member were **insufficient (including perinatal) or negligent; lack of privacy; lack of information in hospitals to talk to someone "skilled" about their bereavement.** My recommendation is that the NHS needs to invest (versus withdraw) **in trained trauma bereavement counsellors who can work directly to support relatives who experience grief and traumatic loss.** This is particularly needed in front-line areas and as required in ward settings. It is not sufficient to expect that staff are resourced to do this. **The fact that so many clients at WBS, over the years, frequently report their interface with hospital care has inadequately met their needs and impacted upon their loss further is evidence this area needs exploring.**

WBS- **One female client explored her regret having a termination of pregnancy in the NHS. She had proceeded (feeling hurried to make a decision) and was traumatised admitted to an antenatal ward and thus with pregnant mothers**. Following her procedure, she was placed in a post-natal ward witnessing new parents and seeing and hearing their babies. Whilst she and her husband were subsequently offered counselling, at the hospital, after discharge this was very traumatic for her returning there. My client identified it was also too early on, which had further impacted upon the strain in her marriage.

Hospice care- a sense of feeling "should be grateful" with conflicted feelings as dying family member in-patient admission length of stay could have been earlier. This reflects that hospice admission times in London, for the dying, are reduced to 2 weeks to a few hours. Such clients shared feeling unprepared despite the staff "being very good". Not feeling local hospice counselling was sufficient or too soon. Recommendation -further research needs to be done to determine when bereaved clients in hospice settings are contacted and if they would have preferred follow-up, or known how to access a different counselling setting.

NHS work- I've worked in intensive care units, including as a bereavement nurse counsellor where there was a particularly high diagnosis of "brain stem dead" patients. This emerged from sudden trauma usually arising from road traffic accidents. I worked alongside specialist organ donor nurses (SNODs) who were not allowed to have their designation on their name badges. Instead their badges depicted "clinical nurse specialist". To my mind this was covert and supported inauthentic contact with families. I witnessed this often emerge in a professional befriending manner by SNODs, who work to targets, that build-up over several hours before organ donation was suggested. The difficulty too was then if families declined the SNODs disengaged from them because of their workload. Their on-calls were extensive e.g working hours 09:00-17:00 and supporting a potential donor call just before 17:00 meant they would have to work until the next day, or be called to another ITU to engage with a new family. They did not have to access mandatory clinical supervision.

NHS- **"Beating heart" donation patients taken to theatre from ITU. These included patients who had tried to complete suicide.** The patients were then put onto room air in theatre (last on the theatre list - so very late at night) whilst

the donation team who were called in to wait (back then 2010/11- see NICE guidelines) up to 4 hours to determine if the patient stopped breathing. Often patients didn't and were returned to ITU to die “naturally” having "failed" the criteria for beating heart donation. Because of pressure on beds they were then often transfered out to a ward to die. Thus ward staff did not know their families. **All these events devastated and traumatised their relatives further and evoked anger and vicarious trauma in staff. This model is un-ethical.**

NHS- Offering laminated painted hand-prints to relatives (or foot prints when people's hands were mutilated, decomposing or traumatically injured e.g. shot; missing). I personally experienced undertaking these prints as a bereavement counsellor as fairly traumatic. The person is dead- their arm weighs a ton- asking a nursing colleague to help was never a problem. We used to attempt to get a “good enough” print several times. The impact was visceral and it felt crazy painting dead hands red-blue- yellow to fit A4 paper- as my own memory was of my childhood hand-paintings then for fun. I’m not sure it was the right time to give to relatives who left sobbing clutching them. This practice was on one ITU and further work needs to support if this practice could be offered later eg funeral home

NHS- End of life care work is now extremely target driven (CQUIN) investing more in payment outcomes that bear no relation in practice to how **more trained bereavement practitioners could help reduce the impact of traumatic bereavement and vicarious trauma-** Including tracking onward referral and staff support.

B) A bereaved client(s) with a psychotic process - please outline how the psychosis manifested in the client and any additional significant information/ experiential knowledge gained re working with a psychotic grief process.

A paranoid-depressed client in his mid 50’s who had experienced two family deaths (mum & dad) 8 & 10 years previously. He presented on anti-psychotic medication prescribed by his psychiatrist and had been referred by his GP. My client had no thoughts about attending initially.

At the start of his work my client was very depressed with little narrative and the occasional threat of violence towards the persecutory injustice he'd experienced since his bereavements. The silence between us was suffocating alerting me to the transference. Noticing then that my feet felt agitated I invited him (after much thought!) into contact by playing catch with a raffia ball in our room. This supported my client in his next 3 sessions to contact parts of his authentic younger self and also I suspected increased his naming his paranoid angry grief. This was very delusional with increased aggressive quite bizarre thinking about conspiracies against him. As I work with transferential communications, my choice point was to interpret some concerns, including about trust, which I brought back to safety in the room with me. Other times

I suggested he might try to unlock where he felt stuck to free him from his oppressors. I was struck that his more delusional state was also very vivid and creative. He was then often contactful and so engaged which helped ground him. I began looking forward to our sessions more.

He progressively shared locking-up in various storage units over the years, including some of his mother's and his own prized possessions to prevent them being stolen. He'd also lost them! We explored the pace of our work and negotiated to explore the loss his locked up lost possessions created for him. Additionally we looked at the symbolism of how these contents blocked him accessing his feelings about his relationship with his mother. I thus learnt to enter into his lived experience with both his paranoid and depressed polarities and we built trust, whilst accepting his stuckness with his enduring grief that too made him feel impotent. My client shared living two lives one in bed asleep for 15 hours (depressed) or out with his trumpet in a musical band. I accepted that the process was different and more unpredictable.

C) A client(s) whose grief process has continued beyond two years after the bereavement - please add any additional information/experiential knowledge/ practitioner thoughts you have in relation to this.

As above

I have worked with several people who often have not felt ready before to process their enduring grief. **Often their developmental trauma (insecure attachment) has impacted their complicated bereavement process, along with fears of stigmatisation which we have worked through. Some people who have presented beyond two years have primary traumata that have suddenly emerged in our work e.g. sexual abuse, rape, domestic violence, alcohol and drug abuse.**

D) A client(s) who has/had Tinnitus which developed following a bereavement - please add any further information/ observations/ comments which are significant.

I have not worked with anyone yet with tinnitus following a bereavement at WBS.

E) A client(s) who has/ had IBS which developed following a bereavement – please add any further information/ observations/ comments which are significant.

I've worked with a female client who had a history of IBS, which she shared had been worse following her bereavement. **From voicing her feelings about the death of her**

family member she shared her symptoms had improved as she felt less anxious and isolated.

F) Please add any further experiential knowledge you have gained in relation to clients' loss and grief and the impact of bereavement which has not been covered above.

My learning has helped with other clients in my work elsewhere when they have had un-processed traumatic bereavements and loss in their histories.

3. Since the WBS bereavement training:

3a) Have any of the materials remained useful to you? If so, please indicate:

I've kept my A4 file as an invaluable resource! It was helpful to have discussed, in my WBS training in 2012, issues about how bereavement was to be classified in DSM-5. I thread this later on in an MSc assignment.

3b) Please comment on any influencing factors/ sources which inform your therapeutic approach when working with bereaved people (e.g. theory/ literary sources/ personal experience/practice based experience).

Theory/ Literacy sources:- I have read more upon the lived experiences of survivors of suicide from literature reviews.

Andrew Reeves- Suicide book

I draw upon my integrative framework: developmental-relational (Bowlby-Fairbairn, Kohut-Stern; Maroda- Ehrenberg) and transpersonal-existential (Jung-Frankl-Yalom). Transtheoretical-theroies:- Neuroscience (Schore) for safe trauma planning e.g working with my client's "window of tolerance" (Siegel), "applying the breaks" (Rothschild) and working with memory and mourning (Herman).

Personality Specialists- Stephen Johnson, Lorna Smith-Benjamin

My lived experience in childhood was the death of my family members due to different illnesses some of which were sudden. I started personal psychotherapy from the impact in my early 30's over several years. Whilst I try not to over-identify with my bereaved clients, or collude with their process, as a trainee I feel I work better with traumatic grief and loss. I understand people can adapt whilst living alongside traumatic grief and with days and events in life when it feels is foreground.

4. Anything you may wish to add:

I really valued and enjoyed the trainer's inclusion of her extensive clinical experience assessing and working directly with bereaved clients at WBS. I too enjoyed her facilitation during my training and working as part of a small group (N= 6). It has been the most comprehensive placement training I have received to-date to support my integrative psychotherapy training.

And finally, please would you indicate:

Your theoretical training/ orientation: Integrative psychotherapy training

How you identify yourself as a practitioner: trainee MSc integrative psychotherapist (still!) and MBACP registered integrative psychodynamic counsellor

The year in which you completed the WBS training programme: 2012

Thank you for your time and consideration which are much appreciated in completing this Questionnaire.

Reference: Received March 2017

APPENDIX 24

WBS Validity Questionnaire 2017: 5 Years Post WBS Training

Please respond to the following sections according to your experience of the WBS bereavement counselling training and your experience as a professional practitioner working with bereaved people.

1. Training content:

1a) If there were any specific materials which you found particularly helpful to you when you started to work with bereaved people, please identify these.

1) Bereavement and Loss: A Skills Companion by Maggie Fisher and Jane Warman

2) The Anatomy of Bereavement by Beverley Raphael

3) Bereavement: Studies of Grief in Adult Life by C.M Parkes

1b) Please also identify any content which you consider to have been missing from the training and which would have been beneficial to include.

The use of art in bereavement work.

1c) Please comment upon the materials presented during the training programme in relation to your clients' lived experiences of loss and grief.

It was most useful to have **the mapping of the nature of bereavement from a physiological and psychological perspective.** This particularly **helped me to see how the client's lived experience of loss and grief mirrored their developmental, cultural and environmental landscape wired into their cognitive functioning.**

2. Clinical practice:

Please indicate if you have ever encountered any of the following when working with bereaved clients, whether WBS or another client group including within any private practice work.

A) A client(s) who has experienced loss or death as traumatic - please add any additional comments/ observations/ recommendations you consider to be significant for therapeutic practice and knowledge in working with traumatic bereavement.

Yes, young wife only married for 6 months when husband falls down stairs and bangs his head and dies.

Observation: The shock 10 months on was palpable and though she had come forward for counselling it was obvious that the pain was still too hard to share.

Recommendation: **In assessment for the assessor to spell out exactly how counselling will work in that they will have again to retell their story, the unfolding that may take some time.**

B) A bereaved client(s) with a psychotic process - please outline how the psychosis manifested in the client and any additional significant information/ experiential knowledge gained re working with a psychotic grief process.

No

C) A client(s) whose grief process has continued beyond two years after the bereavement - please add any additional information/experiential knowledge/ practitioner thoughts you have in relation to this.

Yes. He lost his mother and in less that 3 months his father was also deceased. Well into his third year he sought help for **depression only to realise that it was linked to his unprocessed grief.**

As practitioners regardless of our modality we have to turn listening from a cerebral activity to a living response to be mindful of and be aware of the other to make an 'I-Thou' connection.

D) A client(s) who has/had Tinnitus which developed following a bereavement - please add any further information/ observations/ comments which are significant.

No

E) A client(s) who has/ had IBS which developed following a bereavement – please add any further information/ observations/ comments which are significant.

No

F) Please add any further experiential knowledge you have gained in relation to clients' loss and grief and the impact of bereavement which has not been covered above.

There is no time frame by which loss and grief can be assessed and as such we cannot prescribe or diagnose a cut off point. Where there is **an impairment** to an otherwise healthy individual's ability **to function on a daily basis, practitioners - in the absence of a medical cause - need to survey the client's family (animal and human) constellation to search for the loss. This can then be linked to 'Cultural Family Bonds in Bereavement'**

3. Since the WBS bereavement training:

3a) Have any of the materials remained useful to you? If so, please indicate:

1) The Grief Psycho - Education Sheet Normalising the Experience of Loss and Grief

2) Dimensions and Attributes of Compounded Grief

3) The Experience of Trauma

3b) Please comment on any influencing factors/ sources which inform your therapeutic approach when working with bereaved people (e.g. theory/ literary sources/ personal experience/practice based experience).

The above **materials are a ready source of information that I use as an aide memoire when working with bereaved clients.** As an **Integrative Psychotherapist** I take a holistic approach whereby I seek to understand and share **the client's phenomenological experience to be guided by them as I listen, with compassion and sensitivity, to their unique narrative.**

4. Anything you may wish to add:

Bereavement and loss is a difficult topic particularly went those particapting are from different schools of counselling and psychotherapy. The experience, competence and profesionalism of the trainer made what otherwise could have been a dull and depressing subject into a most enlightening session. We were all engaged and curious throughout. **We were encouraged to ask questions and to challenge the current thinking on the topic.** I was excited to witness a new way of thinking and to have explained 'The Grief Psycho - Education Sheet : Normalising the Experience of Loss and Grief.

And finally, please would you indicate:

Your theoretical training/ orientation: Integrative Psychotherapy

How you identify yourself as a practitioner: Counsellor & Psychotherapist

The year in which you completed the WBS training programme: 2012

Thank you for your time and consideration which are much appreciated in completing this Questionnaire.

Received: February 2017

APPENDIX 25

Hospital Bereavement Officer Transcript

Anne: Well, thank you for this.
Mel: Welcome
Anne: And what I'm really interested in is your work as a bereavement officer and what that involves you in and also what you kind of pick up around (0.3) how people are around death in hospital and also the kind of things they might approach you about and how that is. That would include some practical stuff, so maybe things around dealing with ashes as well, and also things around what happens if somebody doesn't want to be involved, in say a funeral and so on. I know there's a lot involved for you in that kind of work. Em, but maybe if we start with sort of thinking about, just to get into it, what kind of a (0.4) what would it be like on a Monday morning; what would you expect as you set off and go in on a Monday morning? What would you expect to be meeting with?
Mel: OK. So, eh, my day starts by em picking up the key at Reception because it's the main mortuary key so I have to sign in for that. I normally sign in for it and keep it for the day. Um, eh and Don comes in a bit later on who is the mortuary technician. And so I'd have no idea what has happened, what deaths have occurred; may be adult, a baby or a child, em over the weekend, or of a weekday. If I talk through the weekend; the weekend, obviously because of finishing work on a Friday, em my next working day will be on the Monday morning. So, I go into the mortuary which is where I first start and there will be normally em, a::::, a board with em all the copies of what the porters have brought down over the weekend.
Anne: Mm. (*Nodding)*
Mel: So that can be from zero to eight, eh too:::, could be even seventeen which I've had before.
Anne: Wow!
Mel: And em, these I collect and take them back to the office but, before I do that, I **always** say "good morning" to, em, all my, all my family as I tend to call

them or the ones I look after, even the ones that have families and other ones that don't.
Anne: Oh, right!
Mel: I've always done it. I've always, always done it, ever since I got the post. And em close the door [
Anne: So that's when you go into the mortuary?
Mel: Yes. So lights go on and I go straight over to the board and pick everything up and then just before I'm leaving afterwards, em, I always say good morning again and em, close the door and off I go because they're part of me at the moment and I'm, I feel that I'm kind of looking after them and em, well maybe I'll tell you a little bit more about ones that don't actually have somebody and how that sort of has an impact too.
Anne: Mm. Yes (*enthusiastically*).
Mel: Em: (0.2)
Anne: Is that an impact upon you?
Mel: Yeah, a little bit actually. Yes, em (0.2)
Anne: Mm::.
Mel: That's always (0.3). The saddest part, em would be em dealing with the next of kin. I don't know if that's what you want to know about that too?
Anne: Mm. Yeah. Anything. Yeah.
Mel: The next of kin a::re:, em people that sometimes have just fallen through society, have changed their **own** identity or called themselves something totally different, people that have lived on the street, em through various different reasons of their own. I never know the background of these em, of my no next of kin. I call them my no next of kin because they are my family. Em, and I very rarely know anything about them until you get a few people after a while that will start phoning up or someone will start looking for somebody.
Anne: Right.
Mel: Em, because they've chosen to: be away from their family or something has, hideous has happened. Occasionally you'll get a lot more. What I often find totally amazing, I always will find amazing is that a few of the no next of kin that I will have and deal with, em, will have copious amounts of money; <u>serious</u> money in the bank and I know it sounds like a sort of money thing but I just look (as part of the role) and occasionally will find out through some papers that they've had, em and I just think, how can you have thirty grand in one account and then you've got stocks and shares in another. And when you find out, when eventually the social workers contacted you, or some neighbours contacted you, they've lived in total, in total squalor basically and newspapers piled high since the late fifties. And I often think, with all that money, buy, buy the furniture and I can never get my head around that and I don't think I ever will.
Anne: Mm.
Mel: And, quite a few years ago, em I've slightly done this backwards, with that amount of money, I will still do a hospital funeral (0.4)

Anne: Right.

Mel: but the money there then, I have to refer to the Treasury solicitor. So they will get involved in the next stage of tracking down (0.5)

Anne: Relatives?

Mel: within the hospital. Relative, next of kin, sometimes there's a, some far removed somewhere, in Australia or in the Caribbean – could be anywhere.

Anne: Ughuh.

Mel: But slightly going back to that, em when they are with me for a while, I try and do as much as the information that I can find out, so that will be whatever the nursing staff told me going by what the nursing, by sorry the hospital notes, em but sometimes there's very little.

Anne: Mm.

Mel: There's the sheet that will give you information: obviously it will give next of kin, this and this. There might be a really good neighbour that's been involved with them for a very long while. Eh, and then that neighbour might say ' well, I used to be a key holder'. I can't give that neighbour authority to go into their home to do a search so it would be the local authorities but again, nobody em takes ownership funnily enough. Or wanting to do a search in some particular areas or, as soon as they have found that this person has lived like they have, you know you get you always know that somebody wants the apartment or wants their property very quickly.

Anne: Mm. Mm.

Mel: So you've got somebody that's got masses of money, lived in council accommodation, em council don't actually know their background. Very, very often they have no idea that this person maybe had thirty grand or a hundred thousand, plus all these investments that they've done which again, I can never get my head around. Em so they're wanting me to sort of say, well give us the authority to go in straight away and to clear. There's always a little bit of everyone wanting more because it's a hospital death, the hospital deals with it. Sometimes it doesn't quite work like that because again there's resources and I'm working with the public purse so I can't just go and cremate. Em, but also the sadder part of my no next of kins is em, eventually say I have done as much of a search as I can do, I go and register them at the Town Hall.

Anne: Oh, OK. And you're allowed to do that?

Mel: Yes, I have to do that because that's a part of the role now and I can do that because they need to be registered before obviously a funeral can take place. The very first I did a no next of kin, still not knowing really what I was doing, it's hard, you, this job you learn as you go on. Every day somebody's a new tool for you to have and you keep that and then you work with them and you gain a lot, so every day I learn something no matter how long I've been doing this. And em, the Registrar said "date of birth?. Well, as much as the information that patient could give you before they got unwell". So you give that date of birth and they next said the address they were living at which is more or less what one has. And

these are the bits that always make me sad: "Where were they born?" "Oh, don't know" (*Mel's reply to Registrar*). Em, "Were they married or were they divorced?" "I don't know" (*Mel)*.

Anne: Mm.

Mel: Em and then, em, "Next of kin?" "I don't know" (*Mel)*. And my name goes under the next of kin as 'occupier'.

Anne: Oh.

Mel: And em, the very first time, I remember the Registrar saying to me: "Well, you're the occupier of their souls".

Anne: Ah!

Mel: And, in a way, in a way, it kind of really hit home, just (0.6) how important doing this job was. I don't think it's, you know, you're not looking for flags in the air and saying how brilliant it is but just actually how important it was to lay that person to rest and also look after them. It doesn't matter what because I do get letters from families (*coughs and clears throat*) excuse me, that will em, a daughter or a son and just say 'I really don't care what you do with my mother or my father' (*spoken quietly by Mel*). I'll write the letter and they can burn them, you can dig a hole or throw them in the Thames. And what I have to do is respect their wishes but also out of dignity I still have to respect that person that I still have (*the deceased*) 'cos I don't know what's gone on over that and they wouldn't even em register their mother's or father's death.

Anne: Mm.

Mel: And that's a very hard part too, in just thinking 'what have you done?, Mr so and so or Mrs so and so but yet you've got loads of money and that child or that son doesn't want a touch of any of it. Em, sometimes on the opposite side as well, still going down as occupier, it's just sad that somebody that's just lived just the most saddest life ever; very very very private and I'm amazed how someone can be so private, from living in a town or city especially as we are here in London, and yet you can be so far removed from everyday (0.4) living and em, then you'll sort of even get a far removed cousin or somebody saying 'I'm not responsible for them and I don't really care again what you do with them'. People can be very private and I suppose as people say London yes, is a town but you don't know who you see every day sometimes. So that's the, I would say is the very sad part on a personal level for me and it's funny we're just talking about this cos I was doing the papers the other day for em, a couple of funerals coming up and I actually felt tears welling in my eyes of this particular person and I just thought this is just so sad. This person's just had such a sad life and they're only (gives age) and they just drank themselves to the grave, literally. And I can remember the doctor saying 'what a waste, they just didn't want to continue'. And it's just little things like that sometimes, maybe because you have such a happy time going on and then somebody realises what a sad job this is for me although people do far, far sadder things. And I find that quite hard. In the month I had to tell two people that em, their brother's died and their sister's died and

one lady had been with me (*in the hospital mortuary*) since December, in fact New Year's Eve which is even more poignant because em, New Year's Eve is a very special time within our family because it's celebrations cos it's my brother's but then this lady had died, because it's my brother's birthday you see. This lady's died and she's been on New Years' Eve and she's still with me until in fact 'x' weeks ago until she had the cremation.

Anne: And when you say she was still with me, what you're saying is she was still with you in the hospital mortuary?

Mel: Yes.

Anne: So there's something in there that you actually, I mean you refer very kindly to them (*the dead bodies*) as your family

Mel: Yes, yes.

Anne: and you actually see them as being with you, still as part of your on-going working life.

Mel: Yea:::h; absolutely. They are still with me until I've got their paper work sorted out and (0.6) *(shrugs, raises eyebrows and smiles affectionately*)

Anne: and laid to rest. And you said good morning to her every morning.

Mel: Yeah. Yeah. But this lady, had everything all completed and there was just one, tiny little piece of paper – I felt quite pleased about it actually - that had this name on it and I happened to have gone through some papers em, she's (*gives age*), she had a lot of connections with (*names a European country*) and this lady's got a Swiss bank account again, and again, em, lived on the (*name of street*) and em, got everything done and registered her; this is always the way whenever I do this, I get them registered, a date has been set for their funeral and somebody turns up and I just have to say well this is crazy, this person here is in (*place location in UK*); this is the same tiny little, like you have on the back of a letter, sent from, a tiny little name. Well, this lady's name was on this piece of paper here so is this a connection? And it was a connection; it was her half sister who (0.2) she knew it was her birthday in the (*month given*) but it's just because it was mail that was easy for when they did a bit of a mini house search for a few letters, there was over a thousand pieces of mail in this lady's flat. But so, and I kind of and I remember thinking, looking at the paper work, you know, tell me, tell me, and I would talk to the paper work as if I was talking to them. Tell me, where is there a clue? And you know, you go back because sometimes they come in with a little bit of property which again, you know you have to go through property and the nursing staff stomach it but you know they bring down property that is still all soiled from when that person came in. But it is technically right because it's still part of their property and stuff that you may have to hand back to the family.

Anne: And that then stays with you?

Mel: That will stay with me, not, not the property that is not worn and is not good to give back cos then I will discard it out of health and safety but em (0.3)

Anne: But it remains your responsibility.

Mel: It remains my responsibility to go through that property, again to see if there was anything else that was there. This lady had a lot of mail and it probably took me a full day actually. I can remember going through that. That's on top of regular work, seeing families. So my other no next of kin family again take a, they **consume**, consume my entire day sometimes but you know, you have to put a stop on it because there's the day to day stuff that I have to do within just seeing, as I said earlier, that could be twelve deaths that I've got to deal with. Em, get those families sorted out, get the doctors down which can be an on-going battle and then going back to my no next of kin. So you have to, and there's a small window, roughly about three months, I try to lay them to rest within that time, em just out of dignity and, it's just not done. You can't keep them for any longer but em remind me if you want more water.

Anne: No, it's fine, thank you.

Mel: Em, a lady that we've had for quite a few months, about six months. (0.4)

Anne: So you're actually, a part of your role and indeed the hospital's role, is to keep people who have no next of kin for as long as you can in the hospital mortuary, during which you are trying to locate their next of kin or find out more until the time comes when you have to make the decision to [

Mel: to say goodbye to them and have a funeral for them.

Anne: and then you arrange a funeral for them with the funeral Director that is commissioned by the hospital.

Mel: Yes and that's why I, I, I do feel that I go into it blind because you can only do so much, the authorities will only do so much and then you've got all this red tape. Well, because you are somebody from eh, well say *(names a Borough*) and somebody died, then they would go to a house search, they will do that but then they expect you then to come back and em, give them authority to end the tenancy. It was just ludicrous. How could I end someone's tenancy as in the hospital and for all we know there could be Picasso's in there and they go and burgle them. It's a really fine line, so all we're after is passport, any bank details em, any pensions, anything, an address book that this person may have kept to their hearts. When you get the housing officers that go in through the local authorities, they're very very good and we have an exceptionally good one here and he's a gem and occasionally again, so this is why, it's like how far do you run within your job?

Anne: Mm.

Mel: Em he's very good and he, I think he tends to care as hopefully I do about getting as much information as we can and if you have a good team, it will work well so maybe occasionally, he'll go to, if it's on the borderline, he'll go and check with the housing manager just to find out some more. But again, it's all very much 'oh the person died in hospital, it's up to them'. Well, OK fine, so they will be mine for now and that's how I see it in that way.

Anne: Mm. It sounds as if there's, it feels as if there's a lot of responsibility that you carry.

Mel: Yeah. It's very hard. It's very hard.
Anne: And it also sounds very complex.
Mel: Yes. (0.3)
Anne: It's quite investigative at times.
Mel: It can be but again, depending, yeah very much, and there's only so much (0.4) you can search but you always get a wall but that's fine, you can climb over a wall or go over or find another way through it. I don't mind that. But it's just finding another link or a chain to it which would be the section of finding out about them. Em, but we could talk all day about my no next of kin! It's, you know, they're my family but it's truly hard and slightly going back to the story about the lady: it was the sister and she came to the funeral and really interesting about (0.6). She had a feeling that she may have been dead and but really, great, great ownership; she came here with like the money in cash to give to me to pay for the funeral although it was going to go ahead as a hospital cremation which was lovely because it's public money but I pay that back into the account. I couldn't believe it. I had to go and call my colleague to count this money with me in case they thought I was going to go off with this money. Great ownership but devastating and then she started to unravel this Pandora 's Box of this lady's life. 'Cos the other thing I haven't told you about is that she had serious, serious jewellery that they had found in the home. Also she had brought in with her. Em, we're talking about diamond earings, there was a Tiffany – it was just unbelievable. Beautiful, beautiful jewellery and I remember thinking how lovely but yet how sad that this lady didn't feel, she didn't wear them and she didn't, I'm not saying adorn herself with them but what happened in her life so that she never enjoyed these beautifully boxed up jewels and never wore them? So, that's how my family are! My no next of kin family.
Anne: And listening to you, it sounds as if, you know even though I realise that these people are obviously deceased, that actually there's something that goes on for you that's a real kind of relationship that you're working out in your mind.
Mel: Yeah**,** because I often wonder why and again I go back and talk to the pieces of paper; but the piece of paper with their name on though is always them. The piece of paper will be the crem paper or the registration of death paper which I've probably had for the past two or three months because you know, I have a file. And you know it's like 'well, good morning, such and such, I'm going to work on you today'. So I'm talking to the bits of paper as if it's the same person I talked to in the mortuary. But you know, does it (0.2) it makes me feel better because it's so sa::d that someone like myself, I'm their occupier and you know, I will go down as their occupier. As far as I'm concerned, while I am in post they will always be a part of me until they go.
Anne: So for you, you actually are dealing with a person, not someone who is dead in the mortuary.
Mel: Ye:::s. No, no, because that person had a life and even with the, again with the letters that I have from children who tell me they don't give a toss what they

do, then I still have to big time respect the siblings or the children but I still have to give that person *(the deceased*) dignity in death as well because I can't assume anything and don't know what's gone on.

Anne: Mm and you're fulfilling a role that no-one else can fulfil for them, either can or won't. And it's fulfilling a particular role and looking after them in death really.

Mel: Yeah. Definitely. That's what I deal with, their death. It's not 'you've been a terrible person'. You know, I don't know. I wouldn't want anyone to judge me so and we don't know what happened along that route. That's the thing about, it's quite interesting about my no next of kin: I don't know what happened to their journey to bring them (0.2) I think I'd like to write a book! What brought you here that nobody comes to see you or, also, you've been in hospital for six months, you've got fantastic beautiful jewellery and you've removed yourself from a sister that was loving and kind. Something went on there. So for the time being my role is to lay them to rest. Again if I want to look at the clinical side of you know, health and safety it could be number 1, 2 3 they've got to go soon, number 1, 2, 1, 2 you go. Yes but that's not if they have a name and they've got a date of birth and that's who they are. That will be it for the time being.

Anne: Mm. And when you first were talking about your day, you said that it could be an adult death or it could be a child or baby deaths. I wonder if you could say a little bit about the baby deaths.

Mel: A baby death, em, would be::: , I'll talk it from the A & E as we are not a high em dependent hospital with, a main children hospital and I have no idea how the em funeral, bereavement officers would deal with children in a children's hospital because that would be a whole other ballgame. If we have a baby or someone that's come through A & E, that again is really traumatic for everyone dealing with it. If they got a blue call which would be the lights and the ambulance, police are in the department within about 3 to 4 minutes of that call because are they suspecting foul play. So you've got all these dreadful, dreadful things from the cot, if it was a cot death or baby was playing a couple of minutes ago and then baby or it might have been a toddler let's say but they're still classed as a baby. The involvement I would get would be that, the paediatric team are fantastic and they've got specially trained nurses and they're brilliant there. My role would be to get involved with the Coroner eventually. Lots of calls would have already been made, Coroner's notified and Police have been notified. The Police go back to the home to check the home and em if there's foul play, we've had a lot of high profile cases in the last few years so it's standard. Doesn't help the parents or the mother or whoever would be dealing with that but it's what's going on and they have to do it by law. So meanwhile you've got the hubble bubble of all of A & E with ah Police and Social Workers and everyone there. Eventually, after maybe a few hours, say it's lunchtime then, baby wouldn't even come down until after my shift so it wouldn't come down until 7 or 8 o' clock in the evening. He or she would say come down, down means to the mortuary and

then again, as I said about picking up all the paper work, I would see a particular sheet notifying me it's a paediatric death. Em, so my involvement would be then from the doctors or whoever was leading the resus (*resuscitation*) which would be the lead nurse, and then there's a team. So it would be the lead who would notify me on the phone and the Coroners. Also, parents are allowed still to view their child if they want to before baby goes off em for a post mortem. Two things with the post mortem: if the child had been unwell in the last few days, and had seen the GP and the GP thought maybe a high temperature or not feeling too good, I would probably say still that it would be 99% a post mortem because no child should die unexpectedly. So unfortunately that's an unexpected death. It's really hard letting the parents know they're not going to have their child for maybe a week or so; it's just not expected especially if the child was very happy playing so I suppose, maybe I'm saying is in the toddler sense because I 'spose that's even more traumatic, well everything 's traumatic, so they would then, I'd have to let them know. Occasionally I speak to dad or mum whoever's involved just to let them know that sadly their baby will have to be going. When we say going that means no paperwork *(i.e. no death certificate*) , baby might go to 'x' or 'y' depending on where the Coroner's office is and where the pathologist is. They have to get very specific and special pathologist and that's very hard in dealing with that. With an A & death I wouldn't necessarily get involved with a funeral because em an A&E death is sort of said like a community death, so it's an outside death cos anyone who dies in A & E, why did they die? They died in a different area, they haven't been nursed and looked after by us so the route of the paperwork is going to be very different. It's going to be very high profile paperwork, baby will come down, possibly do a viewing if parents want that, if baby has to go then they will see baby later on at their own funeral directors. The other side of when I was thinking of babies will be anything from eh (0.6) 13 weeks to a stillbirth and that's em, I have to be really honest, is very difficult. If there's a huge, there's a huge fine line that I find in the last few years about ownership. This is going to make me sound really, really cold.

Anne: I doubt that (*with a smile*).

Mel: Em, it's a huge fine line. I've talked about my no next of kin. The babies if you noticed, I kind of detach myself from it because it's such a can of worms because of (0.4) the baby that died in A & E, that was someone's baby that they loved and longed for and that was part and parcel of their family or they had another sibling that they bring up. Like I said, every death is traumatic, traumatic. The babies say zero to a stillbirth; a stillbirth is hideous. I would not want to go through 9 months labour and then I end up having a stillbirth.

Anne: Mm. Mm.

Mel: But also, and this is speaking on a personal level

Anne: Mm

Mel: I would want to take ownership and deal with my stillbirth baby, I know I would, and also with my child. There is in the outside of the NHS world, basically

you can, em (0.2) a hospital is (0.3) what's the word I'm looking for, is responsible, so we can offer bereavement services so that's absolutely fine, absolutely fine and no ifs and buts about that. There comes a fine line of when it becomes (0.5) somebody else's problem to deal with and then they start treating, OK and then they start treating our facilities

Anne: Yes (*nodding)*

Mel: which are there to help you along the way, **privately** 'but we don't want it at 9 in the morning'. Well that's because it's a contract funeral, that's when things would happen at that time. Does that make sense?

Anne: Yes.

Mel: So then they're sort of saying 'well I don't want it then'. It's really hard because they've gone through a hideous loss, they don't, I'm not saying they don't want to take ownership. They may not be in the right place at that time to do that so therefore that's why our services are there. Em again, 9 weeks, 3 weeks, 13 weeks or (0.2) When is a baby a baby? I'm not sure so it's best for me not to answer. You know there's (0.4) but (0.2) where we're talking about, is very hard.

Anne: So what you're saying is connected with the age of viability?

Mel: Yeaah.

Anne: At one point did that come down to 26 weeks? It used to be 28 weeks but it came down.

Mel: Ehhh. It's 24, it's 24 weeks.

Anne: So it's down to 24 weeks.

Mel: 24 and under is non viability – yes. Very hard, very, very hard if it's your last. You know I've got to try and personalise it sometimes, if it's your last chance or, you know that baby would have been the baby you desperately wanted. It just opens up a whole other can of worms because also, you don't want to let go the factor that you have totally lost something that you may not ever be able to regain again. But it's on the hospital and they just treat that particular side of it (0.2) very hard (*puts hand on chest*) and (0.4) taken advantage. I don't know what's the word for it, I struggle hugely but it's part of my role still, of course, to arrange the funerals but again, talking about the adults that consume a major part, then you've got a baby funeral every month.

Anne: Yes.

Mel: So we are talking possibly on NVFs (*non viable foetus*) and under em, and people calling up and wanting to know what can you do. So if you wanted to send a huge bunch of flowers then actually, you know this is resources on the, on the public money; that is hard and there's no ownership.

Anne: So (0.3), so someone who might have had a non viable foetus, say it was a baby born prematurely at 22 weeks, for example, and they don't want to have a private funeral, they don't, which they could do [

Mel: Ughuh

Anne: if they chose to [

Mel: Yes

Anne: they could have the baby taken to a funeral director and they could make a choice about burial or cremation [
Mel: Absolutely.
Anne: but if they choose not to, then they might still phone up the hospital and yourself and say 'well we don't want to do that and we want the hospital to actually arrange the cremation em, and so on but, we want to have it on Thursday morning at 11 0' clock, next week, eh and we want a bunch of flowers.
Mel: Yes.
Anne: And are you saying that bunch of flowers would be provided, or the expectation is that it would be provided by the hospital?
Mel: No. They know that they've got the services for free but the flowers they would do privately themselves.
Anne: They will do that.
Mel: Yes, they do.
Anne: But they want to have the arrangements the way they would like to have it but without doing it themselves**.** And you have lots of people, bereaved people and your no next of kin family to consider and take care of.
Mel: Yes. Yes. It's sort of, actually thinking well (0.5) cos it's every other month. It's not every month cos there are other factors that have happened before. It's a whole other can of worms that (0.2). It's very hard, the service is there, it's done lovingly and beautifully and it is there sometimes because every, every NVF or the NICU (*Neo-natal Intensive Care Unit)* death. Then we have the NICU deaths; the babies that have been with us for 8 months, 9 months and then (0.2) we do the NICU services. So you've got four parents [
Anne: So the babies have been in an incubator?
Mel: They've been in an incubator, they've had maybe blood transfusions, all sorts of poor things going on with them. They've fought and they've fought and they've fought [
Anne: Mm:. Mm:::.
Mel: and then eventually they come down (*to the mortuary*) to me.
Anne: Yea::h.
Mel: Em, and parents sometimes will wait for a post mortem or if they want to do more for em a post mortem for teaching purposes to learn from it, then some parents will do that (*give permission*). So it's very strange, somebody from zero to 13 weeks give me more hassle than a NICU baby that's been with us for a long while and then the parents say actually we want to do this (*the funeral*) ourselves. So it's a very, it's sort of like zero to 13, 18, 22 weeks will **sometimes** be a little bit more demanding than the ones that the parents or family that have had a NICU death and been for months and months and months and they just want to take that all over. That's sometimes something that I don't understand so hopefully that makes it a bit clearer how I wrestle with that in a way. But just on a personal level because I was just thinking, you know, am I being very cold? Thinking, well actually, actually was this really a baby to begin with, you know, or am I feeling

more gut and sadness because that poor little baby has gone through so much before their life has even been anywhere. And then, you know, my no next of kin as well that I have with me for a long while.
Anne: Mm. I guess for you it's because you're actually heavily involved in such a wide variety of death, aren't you, you know, right across the board.
Mel: Mm.
Anne: Age wise and all the complexities that go with that. And also, that is your every day. Em, I mean that is your from day to day to day.
Mel: Yes. Yes.
Anne: You are literally living within that constant [
Mel: that little bubble sometimes. I call it my bereavement world (*smiles*).
Anne: Aagh. (*smiles)* I think that's a very good expression.
Mel: I always say it *(small laugh)* [
Anne: *(mirrors laugh)*
Mel: and when I do my emails, I sort of say from bereavement world, you know, in house so I always say it. And it **is**. It is actually another world to itself. It's funny, just thinking about explaining it; you know I say 'the babies', 'my NICU deaths', you know because the babies **are so** difficult. The babies, where does that lead, it makes me sound so cold which I don't want to be.
Anne: No. I don't think you sound cold at all (*shakes head*).
Mel: But it is, it really truly is the bereavement world completely and utterly because it's not just those then. You're talking to Coroners, I'm talking to funeral directors. Then you've got, then you'll have a magazine man phoning me up because he's em decided that this fantastic new magazine that's obviously beneficial to themselves and every hospital hasn't taken it on board and that's another in-house battle that I've got with this man that's sending me this magazine. But I'm just thinking, I don't want to give that to people who have been crying or coming in for the past 8 months to see somebody in HDU (*High Dependency Unit)* you know, in a Burns Unit and then sort of saying what's the best way to get a plaque! I don't think my services, or the hospital services, we should be giving out the death certificate. You know, I should be giving out the package as in the leaflet on what to do next because that's not even the other part of the day. Once everything's been typed up, then it's making contact with the doctors. That's a whole other ballgame because you've got some incredibly caring doctors, bearing in mind they're very new because we get an influx of doctors every year and they're great. And as they learn and I often say as I do a little talk 'you will get to know me unfortunately' [
Anne: So you do a talk when they start?
Mel: Yeah; not for too long [
Anne: Mm. Excellent. Great.
Mel: It's really just to introduce myself because as I normally say to them, unfortunately you are going to have a death and you will meet me somewhere along the line. And then I say, others we'll see each other very, very often because

of you are doing care of the elderly, in the Winter months as you come in, so say August toooo beginning end of October, depending on what's going around, the elderly are going to get poorly. So some will see me more depending on the types of death that you have. And I try to talk to them, normally to make it light hearted but to say their jobs will get more and more demanding as their rotation goes on and as the weather and season changes, I will get a bit more demanding of them also. And this is what I've had to struggle with because I've had to become very, very assertive within my role and over the years. Not in a horrible way because I really hate jumping outside my role, but because if I'm not assertive, I can't get that paperwork done. The death certificate is the most important document that the family will have for their next part of their journey in coping with the death; the registration. Without the death certificate which I try to really, really iterate to the doctors is, it's so important because if you can't come down to the bereavement office if the death needs to be discussed, even if that person – the patient – has been with us for quite a little while and they still die slightly unexpectedly and they had other contributing factors to this (*their death*), there's a bit of a (0.3) protocol that still needs to be done by law. All the doctors are well aware of this. I'm well aware of their job. I'm well aware of where they're going around but you'll often get (0.6). If it's a consultant that is far more important in just who they are in getting things done, they will give the same attitude to the junior doctors 'well. I'm too busy. I've got my living patients to look after' while actually the patient that has died is equally as important because without the death certificate, maybe before they've even written it out, they may need to discuss it with the Coroner. The protocol with the Coroner, the Coroner's officer, they cannot probably get that death cert till the next day, em because of how the paperwork needs to be done in the Coroner's office. So that, again, if the patient dies on the Monday morning, they may not even see me until the Tuesday afternoon. And that in a person's world that has just lost somebody, the loss of coming in 2 or 3 days because it's been a very acute 2 or 3 months, or even in the last week, is very, very hard and I see that when I see the family. And, em the anxiety on the phone when they say we've been told to call you and you can get everything ready because you're not listening. Why should you be listening when you've just witnessed somebody dying or you come in and the nurse said 'I'm really sorry, or they see the doctor do the final em, (0.4) account. You know, that people's fixed; heart – no heart for the last two minutes. There's a cycle that the doctors have to go through and then to say this person is legally dead and write that in the notes. The notes are all written up, the nurse does the last offices, family go home. It could be five in the morning. Sometimes they don't even go home. They just wait knowing that the office is open at 9 o' clock. They come with the bags from the Ward that they've just left, they've had no sleep oh!, tears in their eyes, ugh! And I'm just thinking, oh! I just hope the paperwork is ready. Because why should they know what's to happen next? But they haven't been explained that properly but when you've just witnessed your mum or your dad or

your sister this time of the early hours of the morning, that's not going to sink in. All they want is the paperwork so you've got to lovingly bring them back in and explain a little bit of "go home, go to sleep, I'll call you later, there's no point in you being her". Then some people will say "but I've got to go back to Edinburgh. I've got to go back; I've got 5 days and then I've got to go back". "Where are you staying?" *(Mel*) and then you've got to roll it all in, bearing in mind that you've still got six or seven other deaths to deal with.

Anne: Mm. Mm.

Mel: And it's the way that you, how you handle them as a family and as that individual or as a group of people and also maybe just what I've noticed, say an elderly mother or father, and also an only child that might be quite late in their (0.3) , in their fifties and they've got no-one else. They might have an uncle or an aunt or sometimes someone has been a very career minded person which is I think a lot of what's happening these days. They've only flown over, the time spans are quite different and they could be quite demanding. There's lots of scenarios I could give you but the one could be, well what do I do next? I've got my plane to catch on Thursday and I want to get everything done. Sometimes you have to say, you can't do that straight away. And it's taken a long time to say that, not in a negative way but actually' don't do that'. 'You need to go home or go back to the hotel, phone me later on.' Cos this is a big world; it's not a country hospital where everyone's got their community spirit. It's a big teaching hospital, you know. You're staying in a place down the road, you could be staying at (*names a local area*); it's huge and also the time factor, there's delays. So go home but they, they don't hear that.

Anne: No. And I think what I'm hearing is that as well as your no next of kin families, that you're also really looking after those **with** next of kin. Yoou're looking after the bereaved family and / or individual members and you're also trying to manage the doctors [

Mel: Ugh, yeah!

Anne: and co-ordinating with funeral directors and you mentioned Coroner just now.

Mel: Yes.

Anne: We'll maybe be coming back to that later. So, there's an awful lot of sort of interaction that goes on for you and you liaising with lots of other professions and people.

Mel: Mm. There's a whole chain really. Em it's, I feel like the plate spinner that's got everything spinning. You start all the plates and then the one is that i need to get the Coroner's – I need to get that; I need to get the doctors to come down. But em , it sounds really chaotic; it could be and it can be within a day but you have to have a structure and I try to keep as calm as possible because I'm no good to somebody over the top crying with them although you will have tears, you will have tears [

Anne: Mm.

Mel: because on top of all of that going on your bleep goes off and somebody's just had a hideous death upstairs and you know they wanted to see someone now. How are you going to not see them. If there were three of me it would make it a little bit easier but (0.3)
Anne: but you would get called straight away?
Mel: I would get called and say well I'll come up in a little while cos I may have had a family from yesterday's date em, from the day before that wanted to do a viewing and pick up the paperwork and then someone's just died in ICU that could be a Muslim death because we haven't even talked about that yet and that needs to be dealt with.
Anne: Yes, because of Muslim and Jewish faiths because of the 24 hour burial custom. So how does that work for you then, Mel?
Mel: Ughugh. Em with the, a Muslim or a Jewish death, if it is, it's odd if I say straightforward, it's very sort of hospital talk but straight forward means it was an expected death em, there's been no operations in the last eh, month say, or the person that came in for a few days with us, they came in and were just unwell, it was more or less an expected death and they have died. Em, that's an expected death and it is going to be dealt with as quickly as possible. That's fine, the doctor – all doctors are aware – of the protocol that needs to be done, again depending on what time it is. They all come down and they have to come, they have a duty of care. Everyone at the end of the day, we all have a duty of care. We have a duty of care to every single person that we are dealing with, dead or alive and also with their family. If they're not going to come down (*the doctors)* after two bleeps, I'm not bleeping them again. If they know the family's upstairs and they are wanting this paperwork because there's a time frame, again if the death happened late afternoon at quarter past three, the Town Hall is only open until 4 o' clock. So if you're not going to come down and write it out straight away, then that is not a good practice. Let's just say they do come down, I can see the family and then they can go off, arrange it with the Mosque because then the other side of things is they need to then contact the mortuary to see if they are going to pick up em their family member within today's business as in we're still open now or are they going to liaise with the site manager – that's a whole other protocol in picking up a body from teh mortuary after Don's gone home. Now, with a Muslim or Jewish death as well, it might not just be straightforward for the 24 hour rule as such em, it's about the window. And actually, I have to say, there's not really a 24 hour rule and it's nowhere written and I've been told also by the, our Imam as well that it's never been written in but we do know of the importance of it. That goes without saying and it's paramount. So, going back to a Jewish gentleman or lady, say they knocked their head and had a fall, even if it was a mechanical fall – a mechanical fall being they just slipped somehow, then fell and ended up with a fracture – a couple of days later they get very unwell from that, then it **ma::y** have been, although it's mechanical, may be contributal cos they may have hit their head or something. Then the doctors may say well that's

fine but actually it's not fine because that person came in with a fall. That fall needs to be reported to the Coroners just in case it had been leading up to the death. So anyone who comes in with a fall, doesn't matter what religion they are, needs to be reported and that could hold things up for a couple of days.
Anne: Ughugh.
Mel: So there's a lot of background work again that needs to be done. Nothing is ever as simple as its needed to be but again, a death certificate could not be written out for anyone if they were Jewish or the Baha faith or for a Muslim death without that being reported. If it's straightforward then I will see the3 family.
Anne: Mm. So I just wonder out of interest in those cases, would a Jewish or Muslim or Baha family member, would they want to and would they be allowed to have say, an Imam come in and say prayers with the deceased person?
Mel: Absolutely. Absolutely. We've got a brilliant Chaplaincy team em, and they are on call 24 hours a day and we have a Humanist, a Catholic priest, a Church of England priest, a Jewish Rabbi and we've got a very good Imam who is really very knowledgeable and very sensible and just lovely and very approachable for a lot of things. And if sometimes you find you're having a little bit of difficulty with say this 24 hour rule, he is very hands on and he will come in and explain. Yep, prayers are always open and also again, if by chance someone was coming in from abroad, or way out of London, they (*the deceased)* can still see the family later on. It's there for the site managers for them to organise to let the body out to have prayers with the family. That's always there. And if it's a death on the Ward, it's always difficult for the nursing staff which I am well aware of, difficult for the other patients that are in the bed around the cubicles because you've got a lot of people coming in and you can hear lots of crying and, you know, you've got (0.2). It's so sad cos you can't, we don't have the facilities either, I don't think there's any hospital either that you have a private room to die in and the nurses have the most hideous and difficult job in doing that because how can you continue if it's a lunchtime death – you can't plan a death – you know you've still got people to feed, the patients need to be fed and you've got people on the Ward. You might have me phoning up saying 'a member of the family has just come down and you haven't told me that (*a person has died*) but I've got to be well aware which I am, but it doesn't help in anyone's day, that they (*the nurses*) didn't tell them to do that *(come down to me*). They just turned up (*and I have no official notification that a death has occurred)*. So you've got a lot of on-going stuff within the day, within the working bereavement world day because it's so unpredictable. I love it but it's so unpredictable sometimes too.
Anne: Mm. And you have responsibility about whether or not the Coroner needs to be contacted before a death certificate can be issued which makes it difficult for you if a family member comes to you before you know the circumstances.
Mel: Mm, yes. And the nurses and doctors have a hard job because it isn't easy but we have a duty of care to try and help one another because it's not just the death, it's all the other things leading up to before I've even seen that family. And

the family are gutted, they're just sitting around and don't know what to do. And that's a lot of the time I don't know what to do next.

Anne: You've talked about some of the difficulties you face on a regular basis; thinking slightly differently about difficulties you might encounter, do you ever have to deal with angry bereaved people?

Mel: OK. The angry (0.3) yeah, you'll get the, a lot of, it depends how, it will always be with angry, angry, sometimes shouty, shouty but not too much because it's not allowed, we'll throw them out no matter what's going on. But angry or, what's the word, quite aggressive so you know you'll say on the phone em, "I can't see you at the moment" – "what do you mean I can't see you at the moment? I was told I could see you now**.**" And you're just thinking this is not going to be good from that conversation already or, em people constantly phoning you up. Or, this is just not good enough. My mother's been here for 8 weeks and I want this now. And you'll often know because it's been flagged by the nursing staff. If it's good, that is to say communication with all of us is good because they'll say 'not very good family, two siblings are not talking' or you've got, like there's not whatever a normal family is. You've got father and say the two parents met then after that you've got these sub sub families so sometimes I'll get a call and someone says 'you don't let my sister see my mother or my father'. You're not at all a family mediator and I will say I can't get involved in disputes, family disputes. We're only here to look after x, y or z. "But I'm categorically asking you not to let them see my mother." I think, how can you say that? How can you, how can you and actually, let's rip it back! How can you tell somebody to do their job? That you can't let them see their (0.2). Not up to me, not up to me. I won't get into it and so they will see their mother if they've got the chance and want to. So you get a lot of aggression like that or: "Don't write that on here; that's not what they died of". They're having a go at you for what the doctors have already them that's going to be on the death certificate and they will be (0.2). That's the sort of anger but the anger is the whole sort of sitting in the chair and the tight lip and the whole body language crossed and looking at you and if you give them something, they'll just snatch it back or they'll throw something at you. And this is all in the relatives room before you even send them on their way to the Registrars. And if it's going to be a difficult case or a difficult family, again I'll give the heads up with the Registrars because, I'm not saying I know them well but I do from when I go and do my no next of kin so I will say, actually that there's a quite angry family coming in and they're not going to be very pleasant. And they're not sometimes. They really are not. So how much leeway do you say well you had a death or you are experiencing a really hideous death or you watched your mum or dad, or your uncle or your brother – it doesn't matter who. Well that anger is not for us, to take it out on us because you had a lot of problems you never resolved while they were alive and probably you would never go down there. You know sometimes that's going to be a really difficult journey there, the bereavement journey. Well you're in denial anyway, I mean you could even take

them back at the chapel of rest and they'll just go "are you sure they're really dead?". And you're just thinking 'right, yeah' because they've asked to see this person and then they'll still say to you "are you sure they're dead?". I mean that's hu:::ge implications on their journey and we're only 1% of this journey that they're having, leaving the hospital with the certificate if they are to have it. If they're not, they leave the hospital with no paperwork and then go to have a post mortem. The anger and the, I just think it's the aggression and the denial and being so bitter is what I will see with them. And they talk down to you which is fine because it's not my grief. It's their grief and I'm not in that position to be angry at someone that maybe I cared for and, and loved and been angry with that person. These people are normally angry at the world, they're angry at the person that's died anyway. Did they have a lot of anger before they even came into the hospital to see them? Will they ever accept the death? Probably not. Probably not. Probably not.

Anne: It sounds as if there's a real correlation there in your experience between people who are aggressive as you experience them and actually not being able to accept the death. There's that question you raised just now about 'are they really dead?' It feels as if you've experienced a link.

Mel: Yeah. Yeah. When they keep saying it like that. Em and you question yourself saying 'what am I doing in bereavement world?' Because sometimes you're thinking they are going to have masses of problems. If they can't accept already [

Anne: because they've seen the dead body?

Mel: Yes and where are they going to next? Do they take a long time to register the death? Fortunately there's a sort of five day kind of ruling but if you're away abroad on holiday and you can't come back, or you're in the Services, it doesn't work like. And also families are sooo (0.3) I won't say split. What's the word I'm looking for? You know, there's not a normal family anymore.

Anne: They all function differently?

Mel: Yes. Maybe mother remarried or might have had two other marriages and then one child from both of those relationships, cos you don't have to be married. There's a lot of denial that goes on in there and that's for the nursing staff too because they might say you can only have one family in at a time because family A might not get on with family B, or the half siblings don't get with each other. At war! At war even over death. And also to the point of not being able to agree: "No, my mum always wanted to be buried". "No she didn't; she wanted cremation". Well, actually, who wants the burial or cremation? Who is it better for? Is it better for angry family to have a grave to look at something as opposed to the family that cared and are looking on the practical level of 'wouldn't want to be buried in the ground'. It sounds macabre but these are all the sort of things that family will argue about. And then you can have six. You could have a room full of six or seven people so you take the two important ones that are the main ones say a partner and adult child and they start arguing when you're trying to

explain what needs to happen next. "Well I need to register the death". So you're thinking the death needs to be registered and I'm not your mediator here. You're adults and you're talking about someone that loved you, or you loved them and that's the other thing. The love for this person can be so consuming that they're not seeing anything else. They're not seeing the practicalities and actually someone might say 'why should they see that?'. It's only because I'm on the fence looking at all of that. But they need to find a way of dealing with that even if it's only for two hours for that funeral service. Then you'll get the real lovely families and they laugh and joke about it in a way that's easy for them to cope with but also, if a death has been talked about with that person that's been with us and they're dying, and they're talking and bringing in everyone and saying 'this is what I want', this is the music I want, and if that person has had time to talk to their family, they are (0.4) fab people because of the way that that person who is dying is uniting everyone together and they are able to talk and discuss things. And what I have noticed, is (0.4) even with a, a faith so that's Muslim, or Zoroastrian or Buddhist, if you have something of a faith, or someone who practices or a family that practice, I will always know. It's really weird. I will always know because somewhere along the line, they have different coping mechanisms; they cope with that death very differently. So whether or not it's their faith and they know they're going to go somewhere else and see someone, I will always know that they've got something they practice with on a daily basis. And it's interesting, I come out from them feeling a bit refreshed because of their, their take on death and dealing with the death, their outlook is totally different. It doesn't mean that it's any easier but the way they are conducting is different.

Anne: Mm.

Mel: And another very unusual thing within the family, a family that comes from the (*names a local housing*) estate, em with perhaps lots of problems, they'll take care of their own. I very rarely will have a bereavement where there's, let's say, less money in the kitty and (0.3), well they take care of their own, <u>big time</u>. They come and they'll say no it's alright, mate, we're on the case and we'll sort it all out as opposed to the other spectrum where they say 'right, yes, I need to come for the death certificate today' because you just know that there's a lot of money in that estate and wanting to get things sorted immediately. So maybe the person certified on the Ward over the weekend, funeral probably, I would say would be Wednesday. It's quite interesting and em, my colleagues will often say "oh! Is that a quick one? Money in the estate then" just because of how they've got to know the efficiency, the quickness of it whereas in other families it's 'we've got to have the God son here, or the cousin or that person.

Anne: So you really experience a [

Mel: A little bit, a little bit

Anne: As we're coming to the end, from all that you know which is absolutely vast

Mel: I hope I haven't talked too much.

Anne: No! It's been brilliant, Mel, really brilliant. If people were going to do a training in em bereavement work, say as a therapist, a bereavement therapist; what do you feel in connection with your own professional role, what would you flag up that needs to be in that training programme?
Mel: (0.8) Eh, corr, it's really hard cos it's something you do, what would be (0.6) I would say, doing a bereavement training, could you say go and shadow somebody in a hospital?
Anne: Well, OK!
Mel: Just watching somebody and going into the mortuary, talking to the nurses, em and sitting down talking to em, other bereavement people like we've got a little group, that we've sort of go back with each other and talk about the paperwork and things. That's really hard, actually, Anne! I would even say stay in the bereavement office. It's so hard because would there be a programme, there's so much stuff and there's other stuff I haven't even talked about.
Anne: Well I think you've answered it: I think you answered it when you said to shadow someone and even though that might not be possible, what that tells me is that it is actually about learning what the job really does entail; the nuts and bolts of it as well as the experience of it because it is so involving and complicated and, you know. So in a way, you're initial response actually says it all in that using that word shadowing (0.2)
Mel: (*laughs)* Yeah because I was thinking of my JD (*Job Description*) what it was because you could write a very outline thing but (*laughs*) (0.3)
Anne: And it wouldn't cut the mustard would it? (*laughs*)
Mel: No! (*Joint laughter*) No, it wouldn't!
Anne: No, it just wouldn't. (*Joint laughter*)
Mel: Because where would you start writing? But then you could do a flow chart, you would have a very, guide, you know. You would come in and put the key in the door, say good morning to everybody in the mortuary [
Anne: OK (*enthusiastically*)
Mel: Pick up the phone what deaths have you got but from there, you might get as far as picking up the phone but your bleep goes off and then you go back to typing up the things. I think a structure**.** I think with anything, it needs a spine.
Anne: OK (*encouragingly*)
Mel: So a spine; a vague template would be: what deaths have you got for that morning?, have you contacted the wards?, have you, em, what families are coming in from the day before? Just a few flags. GP letters to be typed and faxed out. Em, collating all the property cos the property could take another 4 hours to sort out people's properties. So I think shadow somebody and then sort of [
Anne: OK. So that's really, really useful. And actually, I wouldn't have thought of that, as a spine or a template and I might try and do that from your tape if that's OK with you?
Mel: Of course. Yes.

Anne: And then maybe run it past you if I can email it to you and say how does this look?
Mel: Yeah. Yeah.
Anne: And then you can maybe [
Mel: Then I can tinker with it.
Anne: tinker with it. Would you be OK with that?
Mel: Course I would. Of course.
Anne: That's brilliant. And thank you so much and thank you for all your knowledge [
Mel: You're more than welcome.
Anne: and wealth of information**.**
Mel: Welcome.

(1 Hr; 12 mins;18 secs: 11, 729 words.)

Immediately after recording:

Mel stated how much she had enjoyed participating and that she now realised how much she knew about her job and work which she had not previously realised or really taken on board. She had also found it very beneficial to herself in talking through the different aspects to her work.

I reflected back to her, her great warmth and compassion which she brought to the professional role and which came across so strongly. Also, her humanity in treating the deceased with dignity and as an individual person, not a number in the mortuary.

APPENDIX 26

A Day in the Life of a Hospital Bereavement Officer

1. I pick up and sign for main mortuary key at Reception and keep it for the day. I start my day by going into the mortuary.
2. I enter, turn on the lights, say "Good morning" and go straight over to the board for the paperwork on who the porters have brought down over the weekend or since I left work yesterday. I don't know what deaths have occurred; it could be adult, a baby or a child and from zero to eight. The most I've had at once is seventeen.
3. I gather up the paperwork and just before leaving, I always say "Good morning" again to everyone I now know I'm looking after while they are still in the mortuary; all my family as I tend to think of them whether or not they have family as well as the ones who don't.
4. I then turn off the lights, close the door and go to the office to sort out the paperwork.
5. A bereaved man, upset and crying with bags of belongings from the Ward, is already at the office, waiting for it to open at 9am to collect the death certificate: his mum died about 5am and he stayed at the hospital instead of going home. [The paperwork might not be ready: are the notes written up? Is the death certificate done and correctly written out? Does the doctor need to discuss the death certificate with the Coroner's office before writing it out?] I gently suggest he "go home, go to sleep and I'll call you later".
6. I go through the information that's on their hospital notes from the nursing staff and where there's no obvious next of kin, I start a trail of information of any relatives, or a neighbour who might have been involved with them. I go through their property which I have to keep in case a relative does turn up when I then hand it back to the family. I enter all information in a file to keep track of everything and where I'm up to with each person I'm looking after for as long as they're with me.

7. The phone rings - a relative of someone who died the day before wanting to come and collect the death certificate and any belongings. I check that everything is in order and ready: the death certificate is not yet written out by the doctor. I tell the relative I will ring when everything is ready and page the doctor to come to the office.
8. I phone the Housing department to notify them of the death of one of their tenants and ask them to do a house search for identification – passport, pension book, bank details, address book, correspondence. [Later after the house search, I receive these documents and sometimes their jewellery.]
9. I ring the Coroner's office to check whether one of the latest deaths is notifiable to the Coroner: an unexpected death of a hospital patient who came in following a fall at home. [Yes, it does and therefore the death certificate cannot be issued by the hospital and a post mortem must take place.]
10. I ring the bereaved next of kin to tell them the death is being referred to the Coroner.
11. I open post: a reply to my correspondence and notice to next of kin of a hospital death; the daughter saying: ' I really don't care what you do with my mother; I'll write the letter and you can burn her or dig a big hole'.
12. After phone calls, I open my file and say: "well, good morning, such and such, I'm going to work on you today". I talk to the pieces of paper with their name on it cos the paper is them. It may be the crem paper or the registration of death paper that I've had for two or 3 months in the file. So I'm talking to the bits of paper as though it's the same person I talked to in the mortuary. I'm down as their occupier on the death certificate and while I'm in post, they will always be a part of me until they go. I search through their post looking for clues, sometimes hundreds of letters.
13. The phone rings – a mother whose baby died doesn't want her baby's hospital funeral to be at 9am on the day I've arranged with the funeral director. The family want it at a later time in the day. I have to explain it's a hospital contract funeral which is different from a privately arranged funeral. [Hospital baby funerals take place once a month.]
14. Finish typing up all the information of newly deceased and page the doctor(s) to come down to the office to write out the death certificate. I check with the doctor if there's a reason to contact the Coroner's office to prevent the Registrar from having to refuse the cause of death on the certificate as bone fide for death registration. [This prevents the bereaved

relative from being turned away by the Registrar and having to come back to the hospital.]

15. After tracking down a brother who lives in Scotland, I make a phone call to say his sister died three months ago and she is still with us in the hospital mortuary.
16. Correspondence time: GP letters to fax out; emails to in-house hospital staff from what I call 'bereavement world'; liaison with Coroner's office, funeral directors; letters out to relatives of the deceased.
17. The phone rings – a very angry relative demands that I don't let her sister see their mother in the mortuary; that I refuse that person permission to view.
18. Appointment – arranged for a family to come in to do a viewing and pick up the paperwork of someone who died two days ago. I take the family to the mortuary where Don, the mortuary technician, will have prepared the body for viewing.
19. My bleep goes off to go to a ward where someone has just died and the family want to sort out the paperwork. I may have to say: "I'll be up in a little while cos I'm with a family now".
20. An expected Muslim death in Intensive Care Unit occurs: the Registry office closes at 4pm so the death certificate needs to be written out by the doctor immediately and then I see the family straight away with the paperwork for them to be able to register the death. The family can then make arrangements with the Mosque and for the body to be collected from the mortuary during business hours and when Don is on duty. If it's after Don's gone home, it's arranged with the site manager.
21. I go to the Registry office to register the death of two no next of kin, after doing as much of a search as I can and now having to let them go and arrange their hospital funerals [cremation]. The Registrar enters my name under next of kin on the registration forms as 'Occupier'.
22. I inform the Treasury solicitor about one of my no next of kin family who has a lot of money in a Swiss bank account and financial investments. The Treasury will then get involved in the next stage of tracking down any long lost relative (Australia, Caribbean, anywhere).
23. The phone rings – the local authority want to immediately end the tenancy of a recently, no next of kin deceased and to clear out the property to re-let it. [I can't agree as the search is not yet complete and the person who lived

in the council accommodation was very wealthy and may have valuable goods.]

24. The phone rings – the lead nurse in A & E notifies me of a toddler's death and that the body will be coming down to the mortuary in the evening after my shift. I speak with the parents to let them know that sadly, baby will have to be going which means being placed in the care of the Coroner and pathologist and no death certificate from the hospital. I ask if they would like to see their child tomorrow before he goes for the post mortem.
25. I leave work at 5pm and go to one of my regular weekly activities, a dance class, before going home.

APPENDIX 27

INQUEST CITATIONS

'There is also a lack of research into and understanding of the impact of the inquest process on bereavement and the additional stress and grief that it causes to bereaved people.'

Selected clauses from INQUEST 2002:

(2) … individual Coroners do often try on an ad hoc basis to be sensitive to families' feelings and concerns. The position however remains that families' legal rights in proceedings are restricted: the inquiry is not for them and the administrative framework is not directed at their full inclusion in the process. Families are not resognised as stakeholders with an interest in the final outcome.'

(3) Bereaved families have frequently described the experience as one that adds to, rather than diminishes, distress and that it marginalizes them leaving them with more questions than answers.

(4) However, we remain concerned that the mainstream provision of bereavement support is delivered in the absence of evidence-based research on the particular impact of bereavement and the inquest process.

(6) In Scotland information is provided by an external examination without autopsy known as a "view and grant". This is a thorough and full inspection of body and a review of the records.
In the United States there are specialized scene of death inve4stigators who are trained nurses and these contribute to the process and help the family. In England and Wales there are a large number of autopsies by rotational contractors on a fee for service basis and quality is sacrificed for as a result.
There is no quality control in England and Wales and there is no w3ay of dealing with poorly performing pathologists. There is no structure or central control. Some are NHS and some are from other jobs.

(11) … families are entitled by law to a copy of the report. Coroners Rules 1984 r57 (1) require the Coroner to supply report to 'any person who in the opinion of the Coroner is a properly interested person' on payment of the prescribed fee (none prescribed). Leaflet: 'When sudden death occurs' 6, Post Mortem Report: This report gives details of the examination of the body. It may also give details of any laboratory tests which have been carried out. Copies of the report will normally be available to the next of kin… A fee may be payable.

(12) … we have attended inquests where Coroners have been very sensitive to the needs of families explaining that the post mortem evience is about to be heard and that the family can leave the court if they wish. Suggest training is essential for those working in the system.

(15) Coroner's Review team at para. 103: 'We plan to recommend an agenda for putting the support of bereaved people at the centre of a reformed inquest process.'
Model Coroners Service Charter jointly produced by Home Office and Coroners Society sets minimum service levels – bereaved people have not reported well on this. Unexpected or violent deaths in particular are difficult – at the centre are Police, doctors, Coroner, lawyers.

(16) Being informed of death: 41% received personal visit; 34% by telephone. Little liaison between those informing the bereaved and the Coroners court. – Not seamless. 'The manner in which that information was conveyed also has an impact – it is clear that the ideal is a personal visit from someone who is trained to understand how to convey this difficult information.'

(17) Over half were informed within six hours of the death but one in eight waited between six to twelve hours to be informed, and one in twenty waited 12 to 24 hours.

(34) In relation to inquest procedures this is a legal process that involved bereaved relatives in a procedure about which thy have no choice. In many cases there is a statutory duty on a Coroner to hold an inquest.
Under section 8(1) of the Coroners Act 1988 the Coroner is obliged to hold an inquest if there is reasonable cause to suspect the deceased a) has died a violent or unnatural death; b) the cause of death is unknown; c) has died in prison or in circumstances requiring an inquest under any other Act.

(39) In marked contrast to the scenario described is the "unexpected death of a loved one" through violent means such as murder, suicide, or following a struggle' – least expected of deaths is automatically accompanied by more traumatic events.

(40) … re quality of life, 'survey results highlight a widespread negative impact of sudden death bereavement on respondents' personal relationships. Family relationships in general (44%) partner-relationships (37%), other friendships (34%); and workplace relationships (25%) were all found to suffer extensively.'
INQUEST survey: impact on bereaved families in the Coroner's court. – Impact on the bereaved of sudden death followed by an inquest.
Enjoyment of life question identified as having deteriorated by 74%; 14% = no change; 2% = an improvement.

(42) … sudden death bereavement exposes survivors to high risks of subsequently developing physical and mental health problems, and of continuing disruption to relationships and soial function.

Reference: INQUEST (2002) How the inquest system fails bereaved people: INQUEST's response to the fundamental review of coroner services. INQUEST.

APPENDIX 28

Luminary Police Officer Transcript

Anne: OK we are recording and thank you for this interview. So in the Police you have the family liaison officer (FLO) and their role is really important with bereaved families, or families who are being told that someone is seriously injured or dead. Could you say something about their role?

Sam: Yes. The FLO is integral to the investigation whether it be a C or D investigation, whether someone's been murdered or seriously assaulted from a road traffic perspective which I've got direct experience of. The FLO becomes integral simply because they can feed into what may be an SIO – a Senior Investigating Officer needs when they finally prepare the report for the Coroner or for any court proceedings that may happen. So the CPS (Crown Prosecution Service) may need, it may need to be referred to them, for them to decide whether or not there is a case to answer. From my point of view, how I work with any FLO's, you find that they can sometimes link into a lot of important information that you would not get [

Anne: Right

Sam: sitting in the police station. You know, they can give you the dynamics of the family or give you (0.2). It just helps build a picture of the deceased person or the injured person. And it does help with the inquiry.

Anne: So does that help with how you then proceed with the inquiry and any kind of contact with the family?

Sam: It does. It does. And social standing has a big bearing as well. Em, simply because (0.2) we'd still deploy a liaison officer to families who've lost people who may be (0.3) involved in criminality and certainly in every case where I've deployed an FLO, you've got to do a risk assessment before you put them into a family.

Anne: Mm. Before you put the FLO into the family?

Sam: Yes and I've heard an FLO work for a family where, you know, they were very anti police em, but they still needed to be dealt with by the FLO. And eh, it was over a protracted period of time over 3 months, they did soften but you had to be conscious every time you put that FLO into that house. They could never really go on their own without some backup outside.

Anne: Sure.

Sam: So there are lots of considerations before you can put an FLO into a house.

Anne: Mm. So I guess in that situation they would possibly meet with a lot of aggression.

Sam: Mm. Mm. It has happened. Thankfully it's rarer that that happens cos, but sadly it does (0.1) on occasion but, you know, the FLO is a vital link and they've got to be deployed. It's a mandatory requirement that everyone who's lost someone or has suffered a serious attack or assault, they (relatives) have to have an FLO.

Anne: Mm. And when the FLO goes, how do they kind of deliver that message if you like, that someone's died? Do they say it immediately, or is there a slower build up to it? How do they approach it really?
Sam: Mm. They're not to tip toe around the truth.
Anne: Mm.
Sam: It's not immediate, as soon as someone's opened the door but there's a very brief introduction and then it's clear, it's down to business and they've (FLO) got to say the words "Your family member is dead"' or " very seriously injured" or "been killed".
Anne: Mm.
Sam: They can't use euphemisms like em, 'someone's passed away' or ' he's not with us now'. There is a story in (names the geographical location) of an officer who did go and say ' I'm sorry they're no longer with us' and they took the family to the hospital, to the mortuary to do the ID and it just, it, the penny hadn't dropped [
Anne: Ye::s
Sam: They'd just not understood that that person was dead.
Anne: Yeah
Sam: And it caused all sorts of ructions and so the answer is, yes they do deliver the message quite expediently em, cut to the chase but then it's quite formal because they do go through a signing of a contract of what can be expected from the FLO by the family. You see, it's quite funny because we all work differently and some FLO's, their rule of thumb is don't get so close to a family that you'll end up going in the morning and making them some dinner. But there are FLO's who go to that extreme and then there are others who just do the bare minimum and I find, having worked with both types, that the one that doesn't get too involved is the better one.
Anne: Mm. Yeah. I imagine that's partly because they remain objective and can give what information is necessary and helpful but they don't get caught up in the emotion.
Sam: Yes. That's right. You've got to question really someone's (0,4) I think you've got to question someone's em wish to be an FLO if they get to the point where they're calling round on their days off and [
Anne: Absolutely.
Sam: you know, seeing how they are and carrying on visiting them years after their loved one's died. I think it's questionable. I think probably they need a bit more than we can give them in the role with the FLO.
Anne: Mm. It's interesting you say that because you can sometimes, in my field you can sometimes see that, particularly around trauma and sometimes within the nursing profession as well you get nurses who maybe have nursed a child who has died and they're still years after, sort of going to family celebration events and so on and not actually distancing themselves from the family.
Sam: Mm. I understand that. I once dealt with a fatal road collision where I was invited to the funeral. Eh, I didn't go and that was my choice but I felt slightly to blame because I'd kept the family very informed throughout so every time something happened or we turned a corner, [
Anne: Yeah
Sam: or every time the CPS had said something, I would ring thinking that the family would appreciate it and I found myself, I put myself into a corner really.
Anne: Right.
Sam: Eh, and even after the funeral they had some kind of ceremony where they scattered ashes and it was months after and I got invited to that and I didn't go there either. Eventually, I just weaned myself away from the family and I think they then realised that I wasn't going to be there for them. But I put it down to my fault really. How I dealt with them in the initial stages.

Anne: When you say that, is that because you were particularly helpful to them? Helping them with a difficulty?
Sam: I think I was and I think I've always been quite candid about everything's that happened. I said earlier that some SIO's em, are not, they tell the family the bare minimum.
Anne: Mm.
Sam: They leave it to the Coroner or the Crown court judge to tell the family how their loved one died, you know, and how horrific it was. I, I tend to do it, tell the family myself how horrific things are. Then I felt I needed to support this family because I'd told them how horrible it was.
Anne: Mm. Mm.
Sam: So I think maybe I was paying back really for what I thought they might find hard to take.
Anne: Mm. So you were taking some kind of responsibility [
Sam: Yeah.
Anne: for having given them the awful detail?
Sam: Yes. Yes. I think so. That's how I kind of judged it.
Anne: Yeah and it sounds as if you've kind of reflected upon that since and you don't do that quite in the same way now.
Sam: Well that's why I've looked at the FLO contract. It's very rigid about 'this is who I am' and ' this is my number' and ' these are my days off' and 'I will not be available then however when I come back on duty on such a day, I will be contactable'.
Anne: Mm. So it's really boundaried, you know, giving clear boundaries and keeping it (0.2). I suppose that alerts me as to how important it is to keep it within the professional relationship.
Sam: Exactly. Exactly. Impersonal really, even though you could come away and you know, some events that you've maybe dealt with are heartbreaking and you could cry on your own afterwards, you've got to be, I've found it's better if I treat it as though it's all a big show in work and then I'll think about it when I get home. But it's far better to give defined boundaries.
Anne: Yes. And that sort of (0.3). What do you do with that kind of, with the horrible stuff because you were in road traffic for a long time and dealt with some very difficult, awful, pretty awful actually [
Sam: Yes.
Anne: terrible situations? So how do you process that for yourself? What happens for you when you're in that situation or immediately after?
Sam: Em, hem, well from a professional angle if you deal with an horrific event, we're offered critical incident debriefing (CID). Em, prior to being in roads policing, I was in (names a local area) and I dealt with two particularly, not violent, but sad deaths in one week and one was a child in a swimming pool who died and the other was on a railway line. And *(a quiet laugh*) we got CID'd twice in the space of two weeks and it was rubbish. (*A quiet laugh*) I just, eh, (laughs a little louder) listened to the SAME rubbish for two weeks and came away thinking 'how did that help me'?
Anne: Ye::s.
Sam: I mean neither death really, this sounds awful and I'm not cold, but neither death really shook me because I didn't have hands on experience with either of the deceased children, there were other people in that group who had given resuscitation to the child unsuccessfully and then, you know, other people who had been nearer to the child on the railway line and I was about 10 feet away though 'hhhhhh' near enough. Em, but it didn't help. The CID within the Police, i think is very shallow and anecdotal and whoever gives the debrief are probably well read, they've probably read stuff about debriefing and churn out this old story. They recited something about, it was some woman who wore red shoes, a bit like the character in Schindler's List – you see a child in a red coat and the film's in black and white, so the child stands out. Well, it was that kind of feeling that I got from the debrief and I thought this isn't helping me.

Anne: What you're saying there, it doesn't sound as if it was direct – directly related to the experience you had and witnessed whilst you were there.
Sam: I think they talk about grief, generally.
Anne: That's interesting.
Sam: I think it's just 'this is what grief can do to certain people'. One of the guys who gave the debrief, he dealt with a, a house fire where someone had (0.3) em (*grimaces*) (0.2)
Anne: Yeah (*nods in shared knowing/ awareness*)
Sam: burnt to death and then he recalled this event of going to his mother-in-laws for dinner and she had cooked pork and he walked away and didn't come back for five days and I thought well that's not really helping me, that's how you've dealt with your grief.
Anne: Mm::: !
Sam: So I think they tick a box.
Anne: So, that's what you meant about anecdotal because she'd cooked pork and it has the same smell as a body burning.
Sam: Yeah. I mean I've been to a, I've dealt with a really, well they're all bad when people die in a fire but a house fire where a couple died when I was in (*names locality*). and that still sticks with me really.
Anne: Yes. Is that [
Sam: (*laughs*) and I didn't smell pork!
Anne: *(laughs)* Is that the visual image that stayed with you?
Sam: It is. It is, yeah. It's visual but also I was hands on in that because it, you know, they were taken to the mortuary and for continuity purposes, you've got to follow, or a patrol has and I was a constable then so I followed the ambulance to the mortuary and one of the nurses said "Oh I can't do this". She was trying to take the jewellery off one of the bodies which had sort of welded into the skin and she said "you've got to do that" [
Anne: To you?
Sam: *(nods*) and I was taking these rings off and chunks of skin to bag them up and put, give them back to the family. So it's got, you know, quite a poignant (0.4)
Anne: Absolutely. Absolutely. Because it's the proximity of that, isn't it and well because it's incredibly involved and it's very intimate [
Sam: Yes.
Anne: in that closeness to the dead body as well and what you had to do.
Sam: Yeah and well what I'm saying is, professionally, they offer CID but they barely scratch the surface and if you were to come unstuck because of grief that you were feeling yourself, em, you'd probably need to seek external help yourself. Thankfully I've never had to do that. I've managed.
Anne: I'm interested that your saying how the CID stuff seems to be very anecdotal , so giving other examples rather than staying with the actual experience of police officers [
Sam: That's right.
Anne: em, and also being more focused on grief rather than trauma because in a way, well my understanding of that, is that actually it is a traumatic event. Of course it involves being dead and grief would be a part of it but in a sense, in the moment, you're not grieving, you're actually involved in the practical aspects of it and exposed to the traumatic event of two people having died in a fire.
Sam: Yeah and I didn't have a debrief for that. I think it's always offered and when I was in roads policing, I would always offer it. Certainly if, the whole section which, that's what would happen, if someone dies on the road, the whole section has to be involved because there are too many roles and jobs at the scene to manage with a couple of officers, whether it's road closures or the FLO or (0.2) and there's your accident investigator so everyone comes together. And if you dealt with say a motorway pile up where someone's been killed, I mean it's a scene

of mass devastation anyway. But just as, I used to have a road death check list and I'd go through it and one of them was offer staff em, what did they call it, it was like de-escalation and then offer staff CID and we would all get together over a cuppa and then I'd say does anyone feel the need for and probably someone may have done but because there's a lot of bravado there cos it's mainly men in roads policing, it would be 'oh no, don't need that'. But maybe someone did need something but I think they would need something deeper than they could have got through the police.
Anne: Yes and so there isn't really a lot of faith in what's available to support the police.
Sam: Not really. You know, you tick the box. Covered that.
Anne: Mm.
Sam: And I used to do a policy document for every death and every serious crash that I dealt with. One of your policy decisions was to look at different strands, forensic strands, if someone had failed to stop at a fatal or something like that. Witness strands and then one of your strands would be staffing, your resources and it would be have you offered CID. As a matter of course which is really remiss of me, I used to just write 'staff were offered CID – not required at this stage, will review.
Anne: Yes.
Sam: And made it look like, and that is it! I engineered it so it looked like I was bothered. And was I? I don't think I was. I dealt with them so routinely that it was just another day.
Anne: Yes. Yes. And I guess that's a part of the job because I know you were on road traffic for quite a while [
Sam: Seven years
Anne: So there's a point at which, cos I can experience that in some of the work I do and when I'm training people I realise that I'm so familiar with some of these horror stories and the people I'm talking to that I'm training, it's the first time they've heard some of this kind of stuff. So I'm imagining at the moment, there's a familiarity that you get used to with some of the incidents [
Sam: Yeah, there is.
Anne: and that there's something that sustains you in continuing to do that.
Sam: Well sadly it's, it all boils down to models. We all follow models. And if there's a road death there are certain things we've got to do. Em, although everyone is unique, isn't it [
Anne: Yeah
Sam: but you do find that you do just deal with them exactly the same, time after time after time. Before I left roads policing which I was glad to do because I think I'd exhausted it really, em my boss said to me there isn't one (fable) that I could give you that you couldn't deal with. But I don't think he said it from an admiring, you know, from admiration for my skills, I think he said it more for, I know you've had enough and you need to move. That's the feeling I got.
Anne: Mm. And was it a relief to move out of it?
Sam: It was a relief to go. I feel that what I do now which is just general policing, is less onerous.
Anne: Mm.
Sam: Em, you know, you finish your shift and you go home and you don't carry anything back with you although you do, I've dealt with death since I've gone back to this [
Anne: Mm.
Sam: in terms of suicide, with a hanging. But again, it's the same sort of protocols as in a road death.
Anne: And you're close to those events aren't you. I know with some of the road deaths, you literally see the body, or body parts sometimes, and similarly so with suicide. You're there with it so you have to face that.

Sam: Mm. You find that it's surreal. I find it surreal. You know, as a young child I used to go to the wax works at Blackpool, the Chamber of Horrors ?
Anne: Yeah, yeah.
Sam: The last display if you like was a, a fatal collision on the motorway and there were all the Emergency Services and there was dead dummies and I used to stand and and look at this and didn't realise that's what I'd end up doing. That was in the Chamber of Horrors and so it must have then (0.3)
Anne: (*smiling)* Gosh! Fascinating!
Sam: 30 odd years ago, have been an horrific thing to, to witness really.
Anne: Yeah. That's fascinating, isn't it?
Sam: I used to stand and stare and me mum and dad used to take me in. – I think I was a bit young really [
Anne: (*laughs*)
Sam: but they used to take me in and they'd say 'it's your favourite at the end' and it was this road death scene which isn't really funny but we all come to an end sometime.
Anne: There's an interesting synchronicity there though.
Sam: Mm. But I was mesmerised with it cos it was clearly like man, woman and there were babies crying who must have been in the back of the car -it was long before seat belts were mandatory – so it was surreal and that's how I've treated road deaths since.
Anne: Mm.
(0.6 silence)
Anne: I noticed earlier yo used the word 'collision' [
Sam: Mm.
Anne: and I know that when I used to collate stats for a bereavement service, it was always down as RTA but you used the word collision.
Sam: Yeah, it changed.
Anne: Can you say something about that?
Sam: Yeah. I mean we would, I called it an RTA and we still do on the radio in comms (communications) and we still say if someone's had a PVA , a Police Vehicle Accident but it's actually a PVC or an RTC. The reason was that by calling it an accident it trivialised [
Anne: Ah!
Sam: the meaning of what had gone on. So if you went to a family and said 'I'm sorry but your husband's been killed in an accident' , that sort of tells the family well, it couldn't be helped this. This is a road traffic accident and your husband's died but it's just an accident. And that's not really the case cos what we say is that every collision where someone's dead, is to be treated as a homicide scene until the contrary is proved.
Anne: Ah! Right.
Sam: Cos there's a lot of em, reasons why someone shouldn't be culpable for a road traffic collision, for example, someone has a heart attack at the wheel and drives off the road and kills some innocent member of the public. Well, that per- the driver has had a heart attack so, even if he or she survived, should they stand in the dock of a Crown court and be prosecuted and possibly get up to 14 years in prison? Well, the answer is no because they suffered an illness at the wheel. So, we moved away from the term accident because of that so if you say to a family your loved one died in a collision, it still leaves the chance or the prospect that someone is culpable and will pay one way or another.
Anne: Right and have you, has it become known that that is more helpful to the bereaved family or person than when it was referred to as a accident?
Sam: I don't know that there's been any study done.
Anne: No but your experience?

Sam: Well, my experience is that people can accept that more. You know if it's been a collision it's easier for them to accept than if you said 'oh they died in an accident'. Some people took umbrage at that really cos it was as though you were trivialising the incident.
Anne: Mm. That feels really important. I can see that for bereaved people, there's something in that that's kind of acknowledging a wrongful death [
Sam: Mm. Yes.
Anne: and linking that to sudden, unexpected, untimely death or if it's someone young and of an age when we don't expect them to die or be dead at that age, then I can see that's psychologically more helpful.
Sam: Mm. Well for example if someone went out and systematically got drunk, very drunk and then got in a car and drove into a pedestrian and you went to tell that pedestrian's family that they'd died in an accident and the driver may well go to prison, they could always come back and say 'that was no accident'.
Anne: Yes.
Sam: And they're absolutely right, it wasn't. So we had to change the terminology.
Anne: Oh I can see how it's a really good thing. And I know again earlier you mentioned the Coroner.
Sam: Mm.
Anne: Em, obviously a lot of the stuff that you deal with, not just in road policing but all police work, so for example with the suicide you mentioned, that you must have a lot of contact with the Coroner. That must be really helpful.
Sam: I used to more so than now. With the suicide that I dealt with, I informed the Coroner's Office cos it was day time and they've got to be told of any sudden or unexpected death. If someone dies of natural causes they're not interested. So that an inquest can be heard, opened first and usually it's left open until the final day. Mainly in roads policing I've dealt directly with the Coroner. I've dealt with 3 coroner's in this area. It depends where people die. Different Coroner's for different areas.
Anne: Mm.
Sam: But they all need to be notified and I think probably the inquest or the Coroner's hearing is probably the most em, nerve racking court, i think, to go to. And I've given evidence in all, the Magistrates, Crown.
Anne: **Mm**. So what makes it the most nerve racking?
Sam: I think cos the family are there. The family are there and you're talking about their loved one who's been killed in a car crash em (0.4) and the Coroner will use photographs.
Anne: Yes.
Sam: So it's quite harrowing.
Anne: Yes and do they show the family the photographs?
Sam: They ask if they want to remain in the court but they will show them because if there can be a Coroner's inquest where there's a trial by Jury. I've not been to one of those; it's always been sorted out before whether there's going to be criminal proceedings.
Anne: And when they show the photos, are they shown on a screen, a large screen?
Sam: Yes. Yes.
Anne: So it's obviously not an old fashioned system [
Sam: No.
Anne: so it's all electronic.
Sam: Mm. Big white board.
Anne: And enlarged images so the family can [
Sam: but the ones I've been to, the family have always opted out; they go and sit in a side room.
Anne: Have they? So they choose not to see the photos.

Sam: That's right.
(0.6 silence)
Anne: I know there is an issue for some bereaved people I've met. It's not so much been with the police or road traffic police but with British Transport Police. Em, because they often show CCTV footage as well [
Sam: Right.
Anne: as well as photos of em suicides on the tubes. I'm thinking of London in particular.
Sam: Right.
Anne: Where people have thrown themselves in front of a tube.
Sam: Mm. We have used CCTV evidence in Coroner's and it was a case where there were two em, boys on a motorbike and it was never established which one was the rider and which was pillion.
Anne: Ah, yes.
Sam: But one of them died and the other didn't but was seriously injured. Even from the CCTV footage we had, we couldn't tell even with enhancement which one was the rider. We tried with forensics cos there was a scuff mark on the seat, so there's all sorts of leads you need to follow but forensics didn't really establish because even if the scuff mark was caused by a certain type of material thst one of the boys wore, that doesn't negate the fact that they may have ridden in a different way some other time so (0.2)
Anne: So there's no concrete evidence.
Sam: No.
Anne: I spose where that takes me to is that for the bereaved, the parents of the person who did die, then these remain unanswered questions.
Sam: They do, yes. And the Coroner did say that it couldn't be established. So there couldn't be any criminal charge.
Anne: Mm. And do you find that em, people who are bereaved and maybe after they've had a visit from the FLO and whatever needs to take place on a practical level, do they sometimes come back to you em as if they want more contact with you because maybe you were the last person to have seen their loved one, maybe nearly alive or perhaps not but you were the last person [
Sam: That's hard and it really is hard. Every family is different and I'm probably stating the obvious there but every family wants something different. And I've said before if someone is at fault for someone else's death, whether it be a road crash or an assault, the bereaved family can immediately, may initially say 'well we don't want the other person to be charged with anything because either a) my brother was in the car with him and it was his choice or something like he was having a fight with him and they were both at fault and my brother just came off worse. And it goes from that to this acceptance and you do what you need to as a police force and we'll abide by whatever decision you come to. It can start off like that but I get the warning signals and I feel you're saying that now, well let's put the clock back a few months (*means forward*) and they tend then to want well you've proved that he killed him so why are you not doing anything? And that is difficult.
Anne: Yeah. And you, because of your experience, you intuitively know that this is how it's going to play out.
Sam: I don't think I know, I think it might do so I'm never wholly comfortable at the start if they give me that message that they're happy however we play it, that they'll be happy. Cos I always, I think I'm a bit guarded and I'll mention to the investigation team. They've said this however let's not pre-empt, they may change their mind down the line.
Anne: Yes. And I guess that triggers my thinking that this would make sense that when someone starts to grieve that actually different thoughts, different issues come up and people

begin to replay in their own mind what could have happened, what they know and almost kind of relive through it but then their feelings change through that process.
Sam: I don't, I mean I think people want different things. As I say, every family's different and it's because of (0.4), I mean for some families life is cheap and they live by the sword and die by it. And, when you go with that death message, it's not sort of completely unexpected.
Anne: Ughuh
Sam: It's always a possibility if their family member is a drug user or something like that [
Anne: Yeah.
Sam: and they're aware of that and you know that maybe they've been involved in criminality at a higher level such as armed robbery. I think when you go with a death message to a family like that [
Anne: Mm.
Sam: it isn't as much as a surprise as it would be for some families, you know?.
Anne: Mm. It's not a total surprise. It's not a, the totally unanticipated death.
Sam: No and what I've found is when you deal with those families when it's not totally unanticipated, your involvement with them needs to be less or tends to be less. They don't ask any questions.
Anne: Ughuh.
Sam: They don't really come back to you. They just deal with it within their own (0.2) clan, if you like.
Anne: Yes. Yes. Very interesting.
Sam: So they never, they don't come back. Now some other families who completely em, unexpect their loved one dying, some will want all the answers and they'll ring you up at home and on Christmas day and just want answers to questions that you can't really give them. You can't.
Anne: No. So they're searching for meaning, they're searching to make sense of what's happened and there are no real answers to that.
Sam: I think it's linked as well. I think it is linked to and I might be wrong and speaking out of turn but (0.5) maybe social status and financial status as well and I've dealt with a family who I would class as quite wealthy who wanted a lot more from the police than really we were duty bound to give.
Anne: Mm. Ughuh.
Sam: They wanted more and (0.3) it was the most arduous enquiry I've ever run because of that really.
Anne: Right.
Sam: And I think the wealth and the whole em, (0.2) opinion of where they stood in society made them think that they were entitled to a better service delivery than anyone else. And so that was hard.
Anne: Yes. Yes.
Sam: Because they weren't. You know, it was just a sad, sad, tragic incident.
Anne: Mm. And for you, you would do the same for whoever, whatever family.
Sam: Yes.
Anne: You don't distinguish and have elitism, basically.
Sam: That's right, yeah.
Anne: And this is the important thing about you holding to your professional role.
Sam: Mm. That's part of being able to deal, really. Cos if I go away and give more than I give another family, based upon their own ele-, you know elevated perception of themselves, then I'm not doing my job.
Anne: No.

Sam: And I can't deal with that then because I think I've been unfair whereas if everything's sort of in a box and quite rigid, I can deal with that cos it's like a surreal investigation and not really think about it at home, cos I don't want to think about it at home (*quietly laughs*) .
Anne: No, of course not (*said seriously*). And it's the same for me and for other people in similar professions and I think that's the real importance, isn't it?, about having a professional perspective and the professional boundaries and the context is the work context.
Sam: Mm. I think you can care too much in a job like that, you know, where you're dealing with people's feelings. I think you can care too much and I don't think it necessarily makes you better. I think it disadvantages you.
Anne: Yeah, I would agree. Let me ask you a question, if you were em, supposing you were training or wanting to train professional people whether it be police officers or other professions [
Sam: Mm.
Anne: who have contact with, let's say, bereaved people, and in some of the cases we've been referring to, what do you think would be messages or a message that you would be wanting to convey to them in their role?
Sam: hhhhhh - This doesn't sound very fair, does it? I'm going to say you've got to be quite a good actor or actress (0.2)
Anne: OK. Right.
Sam: because it is all a game and even though you're dealing with death, death is very much part of life, isn't it? It's going to happen and why bother getting all serious about it. That's for your own (0.5), you know, your own self, really, your own sanity.
Anne: Yeah, self preservation [
Sam: It is.
Anne: in order to do the job.
Sam: Mm. And my advice would be you've got to (0.1) go through (0.2) go through the throes of giving em support without getting too close. You've got to say the right things and even if you don't naturally want to say those things, em (0.2) just say them. And be, try to look, really be very divisive. I think to be a good em, say, bereavement counsellor, or you know a FLO which I do understand, the best ones from my point of view are the ones that don't get close, do the job, do it very efficiently , do it to the point where the family, the bereaved family think 'I'v e had a good service there and it's been professional' because the best FLO's I know, are the ones that come away unscathed and can jump into another job the next day. Certainly in the police, they run on a traffic light system the FLO's and once they've gone red, they're not allowed to take another job on.
Anne: OK.
Sam: Now it may be for a variety of reasons, the main one being they've probably got three or four on the go and you can't really do more than that. It could be that they've got one family on the go and it's particularly difficult and the risk assessment has shown that they need more support when they go into the house or the family than a standard job. Or it may be something in their personality that makes them get too close and they red light. Now I always find that when I look at the FLO rota, the best ones are the green ones and you look at them and you think she or he has done as much work as this person who's red lined but they must have done it more efficiently.
Anne: Ughuh.
Sam: And without all the (0.4) all the (0.3) padding, the unnecessary padding.
Anne: OK.
Sam: I would tell people it is a game and if you treat it like that, I'm not saying you, well if you go home you might think about a particular job and get quite weepy but that's, that won't

last. It's temporary that. It's not insurmountable and if you treat it like a game, that's what it will become and I think that's better for your own health.
Anne: Mm. So what you're saying really is that in order to sustain you in the work, in order to do a good job, and do a good job for the bereaved people, that actually you really have to look after yourself [
Sam: Yeah. Yes.
Anne: and not get caught up [
Sam: Yes.
Anne: and take it on board and internalise it in such a way that you're flagging up, that you're red lining [
Sam: You'll burn out.
Anne: Yes.
Sam: And I left traffic for a couple of reasons and one was that I was going to get promoted in the police, that was the main reason that I left but I'd had enough anyway.
Anne: Ughuh.
Sam: I left at the top of my game. I didn't leave because I'd burned out and I've seen many people leave because they've burned out.
Anne: Mm. Mm.
Sam: Em, and we're all at different stages – I've not got children- so dealing with a road death where children are involved, I don't personalise it and I'm not denying at all that it's harder for some guy or a woman who's got children to deal with an infant fatality, they must find it (0.2) and turn it back on themselves and say what if it was my such a body. I'm not in a position where I do that so I'm lucky in that respect cos I've not had that personal experience to equate.
Anne: Mm. So really what you're flagging up is how as much as it is for the bereaved people and, and their status or whatever that is, whether they're in a criminal fraternity or not, or their social standing, what you're flagging up is the uniqueness of the person [
Sam: Absolutely
Anne: and that includes the officers. It's taking the whole of someone's (0.3) life if you like., you know, into account.
Sam: It depends on the officers' agenda and I didn't really mention that before but it does. I've talked about the families and the status of the family but similarly the status of the officer, where they're at. If they're going through a particularly painful divorce or something. Would you send them into a family if you know they're having a problem with their own lives and I wouldn't. I always try to pick the right people.
Anne: From your team, when you deploy them?
Sam: Mm. From my team.
Anne: So there's a lot of thought that goes into it.
Sam: There is, there is. There's an [officer] I used to work with (*temporal reference*) who got send to a RTC and (*transcript text omitted*) ... similar age to ... couldn't handle the case ... really, really [got] knocked [by it].
Anne: Mm. Mm. So all the thought that goes into it which I didn't know about. One might guess but actually you don't know and I think of what you've said now is not known to a lot of people who do have contact with bereaved people so
Sam: Mm.
Anne: it's been really, really useful. It's sort of like, it puts the bigger picture, it flags up the bigger picture of what happens and what the experience is for people who are bereaved [
Sam: Yeah and I mean stuff like race and diversity are a massive issue as well so em, you know, we've got to be mindful if say we're going to a Muslim family about their culture and rituals and we try and be sympathetic (0.2)
Anne: Yes, so you're culturally sensitive.

Sam: Yes.
Anne: And do you have help with that in the policwe force?
Sam: We do but it's very much down to you as an individual to put yourself up for the course or the input and I always do because there was a road death in which a Jewish person was killed and they had certain (0.3) em, constraints on burial and it needed to be done within a certain time but we needed the body for longer because we needed to do a Home Office post mortem and that's a massive issue as well. So it's competing demands, really.
Anne: Yes and that all complicates things.
Sam: Mm. (*transcript text omitted*)
Anne: Thank you Sam for your time and all the wealth of your knowledge and expertise which you've shared with me.

(47 minutes transcribed; 7,023 words)

This is the same officer with whom I consulted over the PG Certificate 18 months previously, when still in road policing. Since then, the officer has been promoted and remained keen to participate in a 1:1 semi-structured interview. The same officer has also 'taken' a copy of diagram G(T)ED5 for use within the work context in relation to traumatic events attended and experienced by staff.

Katherine Jenkins Transcript Excerpts
Piers Morgan's Life Stories: ITV Studios Ltd.
Thursday, 29th October, 2009

Piers: You were 15 when your father died and at the worst possible age in that period of exams and stuff in your life.
Piers: At 15, you were told dad had Cancer and not long to live.
Katherine: I remember on Sunday when mum came to tell us he was ill and he couldn't 'cos he felt he was letting us down. And it really happened very quickly. You know we were told a good few months (to live) and it really happened so fast. I think it was 2 months when he passed away. Then I was in school, before leaving, in GCSE's study period. Someone said your Aunty is here and I knew then. I walked down the corridor and met her and she said Dad's gone into a coma and you need to come to the hospice unit. So we stayed by his bedside overnight and got the chance to talk to him 'cos it did happen so fast. I hadn't even said goodbye, um, and ... then we went off to stay at my Aunty Jo's for a little bit of dinner the following day. And we were in the car coming back, I felt this urge like I so wanted to be back in that room with my dad, um, couldn't get there quick enough and I walked down the corridor and as we walked in, they said he's just passed away and, you know, since then people have said like maybe things like that happen, You know, they hold on to a time when it is better that they go.
Piers: What kind of man was your dad?
Katherine: Really funny, always joking. Sorry, after all this time you don't think you're going to get so upset. (Tears in her eyes.)
Mum: I think it made her a stronger person and she always believes her father's watching over her. She's always got his support.
Sister: He's definitely an inspiration. His memory lives on and it's really driven us both on, I guess.
Piers: What do you think your dad would have made of your success? He never knew of course.
Katherine: I think he knows what's happened. I think he would have loved it. I don't know if he knew or if he just believed in me. He did used to say: 'one day you're going to be on This Is Your Life'.
Piers: he was never critical of you.
Piers: Do you feel he's here now?

Katherine: Yes. I feel he's telling you not to be too hard on me! No – he is. I feel him when I (0.5) You know just little things happen. When I was in Australia and I stepped out onto the Sydney Opera House and I was so excited to be doing that but my daad had been based in the Navy in Australia and he'd always talked about us going out there as a family. So it was really upsetting to think 'well I am here now and I'm here without dad'. But I have a word with him and I say come on don't make me cry on stage, don't let me be nervous and it might sound crazy to some people, you know it keeps me going to think he is seeing some part of it.

'I had a glass of wine and I toasted my dad.'
'I think him being more worldly wise and settled in himself, me and Laura kind of feel more settled and grounded. And, you know, just constantly felt the love and protection from him.'

Katherine: I used to eat a lot of cereal. I would call it a problem rather than a full eating disorder. I took the Atkins diet too far. 8 months of no carbs. I could not see. I've still got some here but it was hips. I was six and a half stone.

Katherine: One night, walking home. Group of friends, split up, got the bus. Got off at a bridge near Paddington. He tried to drag me down this alley way.
You either freeze or fight. I remember him grunting at me. And the awful thing is, he looked so normal. I thought if I can get in a ball on the floor.
He ran to the end of the road and laughed.
I will still look over my shoulder, even now.

Viewed 29/10/09/ ITV Studios Ltd.

Cilla Black Transcript Excerpts
Piers Morgan's Life Stories: ITV Studios Ltd.
Thursday, 22nd October 2009 – viewed 29/10/09.

Cilla: I was just so totally stunned (at being told about Brian Epstein's death). Bobby was about to deck him. Tom Jones said: 'Hang on a minute' and went away. He came back and said: 'It's all over the radio. It's true.' I came back straight away. Yeah, it was terrible really. He was only 32.
Piers: You were 27 weeks pregnant

Cilla: During the movie, I felt this pain and I was blaming Bobby for this. I said: 'You made me rush my lunch and I've got indigestion now', and I did the show. Still little niggly bits and then at 3 o clock, I – there was just something. I went into labour, eh and I thought I'm going down to London and he said no you're not; we're going to the nearest hospital. And that's when I just went into full labour. And it was awful. I, eh, and my specialist who was looking after me came up actually all the way to Coventry to be with me. And it was just awful.
All I can remember is ( ) I could hear in the next room (tears welling up in Cilla's eyes; draws in breath, shakes head) two women talking about their babies. And I had none. (Shaking head

from side to side) It was awful. (Pulls back her head) Awful. (Arms out to side) Yeah. It was terrible.
Piers: And she lived just literally a couple of [ ]
Cilla: Two hours. (Frowns and horror on her face)
Piers: And you call her Ellen.
Cilla: Ellen after me Aunty Nellie (Smile appears as Cilla says her name) Yeah, and I was awful really because she had to be registered in Coventry or was registered in Coventry and Bobby had to drive all the way back up there and he came back with the birth certificate and it was 'Helen'. And I said: 'No. I don't know who Helen is. It's Ellen after my grandmother and my Aunty Nellie. And he drove all the way back again to get it changed. Wasn't I awful? Well, no it was important to me. It was very important to me.
Piers: I read you said once that you never get over something like that.
Cilla: No, you don't and you don't and you blame yourself. Maybe it was nature's way. I actually said to Bobby, you know, 'Why me?' And it was (0.4) He was very tough with me and he said: 'Well, why not you?'.
Piers: Do you ever wish you'd had a daughter that would be around you now?
Cilla: (I've got my 3 sons.) Well, I often think what Ellen would have been like obviously all the time but I've got two great grandchildren. I've got my Lana who's two. ( ) the greatest joy my grandchildren are to me today. And I do think 'Oh Bobby would have loved this. Oh he really would have loved this.'

Simon Cowell Transcript Excerpt
Piers Morgan's Life Stories : ITV Studios Ltd.
Saturday, 6th March 2010

Piers: Backstage, for your dressing room, you order lots of things to eat (specific foods) – Walker's crisps, Cadbury's chocolate
Simon: I eat the foods I used to have when I was young.
Simon: I freak out at the idea I can't sleep (and takes sleeping pills every night).
Julie (mum): When his father, Eric died, he went to pieces. I never 406ealized how emotional he was.
Simon: It wasn't good but you get to deal with it. My first response was to look after my mother. You believe everyone's going to live forever. And all the stuff you care about, the records, it means nothing. It was horrible, horrible.
Piers: What would your father think of your success?
Simon: I'd love to have seen his reaction 'cos he'd have loved it.
Simon: I can't admit things. I can't go to funerals. I'd never lost anyone before. The first thing like that I had to go to and it's big; it's my father.

Anne Smith Training Materials: **APPENDIX 30**

Tsunami 5 Year Anniversary Documentary
Channel 4, ITV: January 2010
Tsunami Transcript Excerpts

Ts Surv.1 (local resident): After mourning for a long time, I learned that it's not a punishment. It is a test from God to make me a better person, a stronger person day by day.
##########
Ts Surv.2: So daily I put it on myself, sometimes too much to try and do something special. Try and be someone, be better than I should have been and continue to strive because (0.2) you know and I don't feel like they're pushing me to do that, the people that didn't make it. It's more like they're saying 'do it for us'. *(Annotation: Not guilt driven, feels like post traumatic growth.)*
##########
Ts Surv.3 (wife): You may look normal. You go on and you do your normal life.
Ts Surv.4 (husband): Go out. People see you.
Ts Surv.3: You've got to. Nothing changes. You've, you've still got to earn money. You've still got to eat and get on without her (daughter who did not survive with them). But underneath, you're never ever going to get over that.
Ts Surv.3: It was the best thing because you thought you were doing something for Isabella. Very selfish really. I love how we do help other people but it's also for Isabella. So it's little things that help you get through. Like helping Louis, 3 years old. You appreciate smaller things and you take each day as it comes. That's how we cope.
Ts Surv.4: It was like paradise you know. We were ringing everyone we knew to say how beautiful it was. Such a beautiful place. It's a most amazing country. It's rich and it's vibrant. We wanted Isabella to see the colours, the jungles and the animals.
##########
Ts Surv.5: I was there with my future wife and my 3 children.
Ts Surv.5: And then I started to break down and cry. I thought that if I had the faith they'd be OK.
##########
Ts Surv.3: My only thought was Isabella and I don't know how (0.3) I don't remember letting her go. I don't remember that. There wasn't a tearing apart of arms or, or (0.3). The next thing I knew I was without her. I couldn't get my breath. The panic when you can't get a breath and you breathe water. (Can't breathe) Oh God, the panic! Oh I can't imagine a worse death than drowning. I can't. I can't. (Sobs) I'm so sorry that Isabella had that kind of death because the first breath you take is water and you can't get your breath. (Intake of gasping breath.)

##########
Ts Surv.6 (father): We found Collie's bathing suit top and we found Jay's torn jeans and we just dug through the rubble looking for them.
Ts Surv.7 (mother): It was horrific. I just don't have any other word to describe it. We just sat on the steps of the bungalow and mourned. I had hope that they were alive but I didn't believe they were alive. I had accepted that I lost both of my children.
##########
Ts Surv.4: Isabella, I wanted to find her desperately which meant I would have to leave Kim. We were in a very, very sorry state; a very bad state.
Ts Surv.4: You don't stop hoping. You don't stop hoping at all. You do stupid things like 'she might be alright'. Or someone might have helped her.
##########
Ts Surv.8: I had extreme guilt building and building because while we were at the hospital, we heard of people we knew or that we saw that didn't make it. It's horrible because you think what am I going to do in my life that if, that's going to make up for their life as well. Because I made it and they didn't.
##########
Ts Surv.9 (local resident/ employer): Within 24 hours the bodies were unrecognisable. So we could find staff by uniforms, or watches or hair.
##########
Ts Surv.6: We were back at it the next morning. Where are our kids? Are they under the debris? Are they still alive and do they need to be dug out? (Collie) But looking, honouring that last shred of hope.
##########
Ts Surv.8: Then I went to another hospital and found him (older man). I was overjoyed. I was in tears. It was just amazing to see him there in the bed alive. That helped me a lot coping with this guilt eh thing, why did I survive? So I don't feel any guilt because I did my best and that helped me a lot.
##########
Ts Surv.10: I just felt lucky and guilty as well. People on the beach, should we run down and help them? You know in a situation like that you haven't got time to think about anybody but yourself. It's a selfish thing.
##########
Ts Surv.6: We found Jay's name on a list. Jay's alive! My God where is he? He said, have you found Collie?
##########
Ts Surv.11 (mother): She was very dear to me. My other kids teased me that she was my favourite. She wasn't my favourite but we talked about things.
Ts Surv.12 (father): You know when you do see your daughter; it's the most horrible thing you can do. And then when you're asked a few times is this your daughter.... and you say, 'yes, it is my daughter'
Ts Surv.11: And when he came back all he had to do was look at me and I knew it was her. (Cries) And then the rest of your life begins then. (Sobs) Just gutted. Really, life's over.

9/ 11: 102 Minutes That Changed America - (Tuesday, 11th September, 2001)
Channel 4 Documentary: Monday, 7th September 2009
100 plus different eye witnessed accounts from camera archive material not previously shown. Viewer discretion is advised.
World Trade Centre, Manhattan, New York

Audio-Visual stimuli and images: Words, phrases speech used by different witnesses:-
8.45 Explosion
Explosion/ sirens/ shouting/ whimpering/ calls for help/ fire/ thick smoke/ burning debris on the floor/ bodies falling/ people running covered in ash.
WA: "I saw the entire event. I was walking down Chambers Street. I saw the plane. A green aircraft – 901."
################
WB: "It was BA."
WC: "You're kidding. Unbelievable. This is unbelievable."
################
WC: "That's terrorists. I can't believe that! Both towers."
WD: "Both of them?!"
################
WE: "It looked like a United that went into the side."
WF: "Another tower!"
WE: "I'm shaking."
################
WG: "I hope it wasn't a terrorist attack 'cos it's tunnels and bridges next. That's not good."
################
WH: "I can't believe what I'm hearing. I just can't believe it."
WI: "I'm devastated. I have some very dear old friends in the World Trade Centre." (Crying)
################
WJ: "Like confetti – paper floating and stuff falling down to the ground; all the debris."
9.05
Emergency personnel: "Be advised; we have jumpers. Jumpers!"

WK: "Look. Somebody's falling. Somebody's falling."
WL: "What is that falling? Please no; it's not a person." (Then, on the documentary footage, several bodies were shown falling."
WM: "Those big heavy things falling in a way no piece of paper would fall."
WN: ""It's not safe here. It's not safe here."
Documentary footage showed people collapsing from stress and disbelief in the street, and saying Why?, Why?
WO: "Like a ticket tape parade. What did the Yankees in."
WP: "What?! You're kidding me?! Holy Mother of God! I'm stunned to say the least."
9.16 The Police were ordered out of the building.

WN: ""It's not safe here. It's not safe here."
Documentary footage showed people collapsing from stress and disbelief in the street, and saying Why?, Why?

9.25 In the streets: Crying; no cell phones working and people frantically trying to call people; people crouching behind cars; chucks of masonry and debris falling from the building; chaos and a lot of injured on the ground.
9.29 South Tower building: Alarm ringing. 45 minutes after this, the first tower to be hit, no word had been received from those inside the building.
9.35 People were in windows, hanging out and a man waving a white cloth. A call was received; 100 people were trapped. Told:
Emergency services: "Stay where you are."
Em serv.: All you can do is sit tight."
Em serv.: I'm telling you to stay where you are. I'm hanging up."
Survivor: "Only one person said leave – don't know what's going to happen."
9.42 Command Post in Tower 2:
Em serv.: Oh my God! There's a guy hanging (0.2) Oh! There's people hanging out the windows. Oh! He fell out; the guy with the flag.
WQ: "I just can't believe what I'm seeing. Horrible. It's horrible. The smell is unbelievable. Smell of burning wire and metal; it's horrible."
9.53 Evacuation: people were evacuating and being evacuated from surrounding buildings
Em serv.: "We've got civilians walking back into the area."
WR: "I want another camera" 'We walked to the store and then we were right there!' (Told media interviewer)
9.58 First Tower collapsed:
WS: "Thousands of people were running up Church Street. There was a gigantic rumble."
##############
WT: "Help me. Help me." (Heavy breathing)
WU: "Did the building just disappear? Where's the other building?! There's so much smoke; it's just the smoke."
WT: "Can't breathe. Cannot even breathe outside. Stay here." (Crying)
###############
WV: "It's gone. It's gone. Jim, it's gone."
##############
WW: "Yeah, dude. I was 15 minutes away from being in that building. I was 15 minutes late for work. Monday night football saved my life.
WX: "You have to get out." (To a woman frozen, rooted to the ground and staring at the scene whilst others were getting away from the area.)

10.28 Second Tower collapsed:
WY: "Oh my God! Oh my God! Both towers are down."
Documentary footage shows disbelief and the stunned expressions of the fire fighters at the second tower collapsing.
###############
A six year old child said:
WZ: "It exploded and it's not there anymore the World Trade Centre."

Living with Murder': Andy and Christine Jones
Transcript excerpts from televised documentary on 21/9/09
Programme: Crime & Investigation, HD; Mondays at 9pm

18 year old Andrew Jones was murdered in Liverpool City Centre at 9.30pm on Saturday, 10th March 2003. Andrew and his mate Daniel had become separated from the large group of friends in the 411edestrianized bar area of Matthew Street. Andrew's skull was smashed.
Mum: "I still can't believe it."
Mum: "Drs, nurses and police were waiting for us (at the hospital). They said: 'don't be nervous, he's got a lot of tubes attached to him'. I've never seen so many wires and tubes attached to someone. They said: 'we're going to send a priest in to you'. I said:' we don't need a priest, he's not going to die."
Mum: "Everything they were telling me just wasn't going in."
Mum: "Drs and nurses were trying to pull me away from him saying 'he's gone'. I said: 'He's not. He's coming home'."
Dad: "She had to be told twice he'd died and said 'shut up, shut up; don't know why you're all crying; he's not dead' and (she) started laughing."
Mum:" Once we were a happy couple, we're now grieving separately. We nearly separated."
Sister Laura: "I just smelt his dirty clothes. I thought what are you doing? Don't want mum to wash them. It's all that's left of him."
Mum: "I didn't want his funeral. As long as no funeral, he's not gone. I did not want closure."
The funeral was 3rd April 2003, the day after Andrew's birthday.
Dad: "She'd (mum) be celebrating, not sitting holding his hand in a coffin."
Christine decided life wasn't worth living and didn't go to the wake. She went home and went to bed. The Dr had left pills for her.
Mum: "I just took them and told nobody. I thought: 'it's not right what I'm doing, I've got other kids. But they're older now and he's on his own. They'll be alright; I want to be with Andrew."
Mum: "I hated everyone; the priest and everyone. I still hate them now (small laugh)."
Dad: "She said: 'why didn't you just leave me alone? I want to be with him'."
Mum: "Andy finds it hard to keep the family together and to grieve."
Brother Christopher: "Me dad went round punching walls."
The family wanted justice for Andrew and 4 had been arrested but no-one broke under cross examination. Coroner Robello had to give a verdict of unlawful killing. 6 years on, the family have not found peace.
Christopher: "I decided to be me own vigilante."
Sister Jeanette: "I still buy him stuff now (for his birthday). I don't buy him aftershave; I buy him flowers. It feels like yesterday to me"
Christopher: Sometimes I'll just punch some things. Like just after Andrew died, I punched a door and busted all me knuckles."
Jeanette: Mum and dad will go out looking for him, thinking he's gone looking for them."
Jeanette: "He (Christopher) was taking it out on anything that got in his way – walls, doors – and he'd say: 'I never got that pint from him'. He's under a psychiatrist."

Jeanette: "I've got a DVD of him (Andrew); I watch it every day. If I didn't have me kids, I'd have done what me mum done. He wasn't just me brother, he was me best mate. I could cry on his shoulder. I've got a partner but it's not the same. Laura's convinced she's seen his ghost. She says she's seen his shadow walking past the door."
Mum: "We have a 30 year marriage but cracks started to appear. It's hard to be as happy as once we were... It's hard for Beryl (Andy's mum) to see her son suffering... I couldn't tell her how I feel... They can't do nothing to help you... When I'm in the bedroom listening to his music and looking at his photos ( )
Mum: "Andy used to be a lorry driver but not since. He's not the same person he was. I'd like to see a bit of that come back."
Andy and Christine keep busy with the campaigning for the Liverpool group 'Families Fighting for Justice'. It's a fight to save their marriage and to have done something, Justice, for Andrew.
Mum: "A few times I've walked out on him (Andy) and he's got the Police."
Jeanette: "I've got a picture in me bedroom and when the DVD's finished, I look at it and say 'I love you'. I just wish I'd told him more often than I did – 'I love you' – but we didn't do it then. We do now."
Mum: "This pain won't go away. I don't think I'll ever ( )

Concept of remaining attached, continuing bonds and bonds changing over time:

Transcript Excerpt: Lethal Weapon 4

Fictitious Character: Riggs played by Mel Gibson

At his wife's graveside:

Riggs: I haven't been here enough lately, Vicky. I'm sorry. I need to talk to you about Lorna, me and Lorna. Ugh! Well, it's like this. She wants to9 get married. I love her. Oh yeah, I really do. And what am I going to do? I want to make her happy and em, (*sighs),* I'm looking for help here, honey. I, I, I don'[t know what to do. Funny talking to you about this stuff but em,

(Enter Leo character)

Leo: Hey Riggs!

Riggs: Oh Leo! You want to get yourself shot, is that it?!

Leo: No.

Riggs: What the hell are you doing here?

Leo: I was tailing you. I'll leave you alone. I guess you want to be alone.

Riggs: Yeah, I'd appreciate it.

Leo: You know when I was a kid, I had a pet frog.

Riggs: What?!

Leo: Just give me a second, let me tell you this. His name was froggy. He was the best frog in the whole world. I didn't have a lot of friends. Matter of fact, I had no friends and eh, I used to kiss the frog too. I thought maybe eh it would turn into a princess since I was a boy and eh, could be my mother. They told me she left or something and my father was no bargain. And so, just the frog; froggy was my friend and I took him everywhere with me. And I was riding on my bike one day and he jumped out of the box. And eh, I ran over him with the back tyre.

I killed him. I was really heart broken. Really. He was my best friend in the whole world. The only thing I ever loved in the whole world. And then I met you and Roger. And you guys looked after me more than you needed to.

Riggs: We're terrible to you, Leo.

Leo: It's OK. You're my family and my friends. You're not better friends than froggy. You're just different and I thought that just might be relevant. OK, I'll leave you alone now.

(Leo exists and Riggs looks back to his wife's grave)

Riggs: You sure picked a strange angel, honey but I got the message. Here; I'll always have this (*takes out his wedding ring and holds it up).* I'll always have you; you hear me! Thanks, honey. I gotta go.

Although a romanticised version for the screen, it is nevertheless representative of how bereaved people do talk to their loved ones including about dilemmas and difficulties that arise in on-going life.

Establishing a home with a new partner can be a very difficult decision to make with feelings of being disloyal and betraying to the partner who has died.

‘Empty Arms’ Video : The loss of a baby during pregnancy
Selected excerpts for transcription from 3D Yorkshire Television (1993)

Excerpt 1:

Tasmin has had several pregnancies; five miscarriages. This last miscarriage was a baby boy who lived 9 hours at 27 weeks.

Tasmin: Dr Catherine came in and said you know his heart beat’s gone very slow now but they’d given him an injection to bring up the heart rate but it hadn’t been working. It’s his way of saying he’s tired and he’s dying. [ ] They asked whether I’d like to hold him so I said ‘yes’. They took him out of the incubator in a blue blanket and gave him to me. And he was still warm when I was holding him. And he had a lot of drips in him so I asked them to remove one from his hand and, em, as they took the drip off, i put my finger in his hand and he clenched his fist and that’s when he died.
Liz: It sounds quite special.
Tasmin: It does. There was time for us to say goodbye almost.
Liz: And he was holding on to you.
Tasmin: Yeah.
Liz: And you called him?
Tasmin: Geneed (pronounced Jenaid), Mohammed Geneed because we’d known he was going to be a boy, we thought of names (Tasmin smiles) so we were quite prepared to name him. It’s just a pity he never lasted longer.
Liz: That he didn’t stay with you for a bit longer.
Tasmin: yeah. It’s very easy to talk about a baby afterwards when they’ve been alive. Through my miscarriages before, we were never able to talk about him.
Liz: You weren’t able to talk about the miscarriages before?
Tasmin: No. It was something you don’t talk about at home; it was too upsetting. You know there was nothing there you could talk about apart from it was my loss, nobody else’s. No-one seen them alive whereas Geneed was different. He was a person in himself and if I don’t talk about him then nobody else can, you know.
Liz: You want to remember him.
Tasmin: Yeah. It’s a way of keeping him alive, is letting other people know about him. Who can actually ask about him tomorrow. You know and say well how are you about him? How do you feel?
Liz: And he’s part of your family now.
Tasmin: that’s right. Although he’s not there, he’s there for me and he’ll always be there (said with a big broad smile).

Excerpt 2:
Joan had a miscarriage early on in her pregnancy. She has two other children.

Joan: It felt very much like a baby and I felt very pregnant. I think I felt very strongly that it was a person.
Ruth: The hard thing about miscarriage is not having someone to see, someone to grieve over.
Joan: I think that's quite difficult, maybe what other people say to you although they mean very well.- 'Well maybe it was for the best; you've got two children'. I think it's very difficult for people to understand. Even though they tell me it's easy to get pregnant again, I shall always feel worried about it. I think it will make me feel sad, the next time 'cos it can't be a replacement for this baby. That's the thing: I think people think that another pregnancy will take the place of this one but it can't.
Ruth: What may help is actually marking this baby's life in some way. Some people like to plant something or to write something down to actually acknowledge there was the life and that you did have a baby.

Excerpt 3:
Yvonne gave birth to a baby girl, Emma, at 26 weeks (a non-viable foetus - NVF) who lived for 4 hours. The main part of the documentary focuses on Yvonne, husband Tony and Haley, their seven year old daughter as they cope with Emma's death in the hospital context.

Yvonne: It's just been amazing. Completely different to the other two miscarriages. Although I was allowed to hold them, then it was just all over. You just sort of were whisked off to a ward and there were other babies on the ward. But this time it's been amazing. It's hard but just to have her with us [ ] she's real. She's our real daughter and she's been treated like she's our daughter.
Tony: I know now I've had a daughter.
Yvonne: We were allowed to get to know our baby.

Excerpt 4:
Liz Hopper, Senior Midwife-Counsellor speaking on the documentary.

Liz: The woman does need to go through a labour; does need to deliver the baby herself. That can be quite a shock to people. She thinks and often her partner thinks that perhaps the easiest way is to have a caesarean section but it is helpful for her to know that she's actually lost the baby, rather than to be put to sleep and to wake up and suddenly find there was no baby.

Excerpt 5:

3D presenter, Julia Somerville for Yorkshire Television (ITV, 1993) closed the programme saying:

Julia: It's been seven weeks since Emma died. Last night we spoke with Yvonne and Tony. They're still struggling with their sadness but they wanted the film to be shown. They said, again, 'we really hope the programme will help others. The pain of losing a baby is so great'.

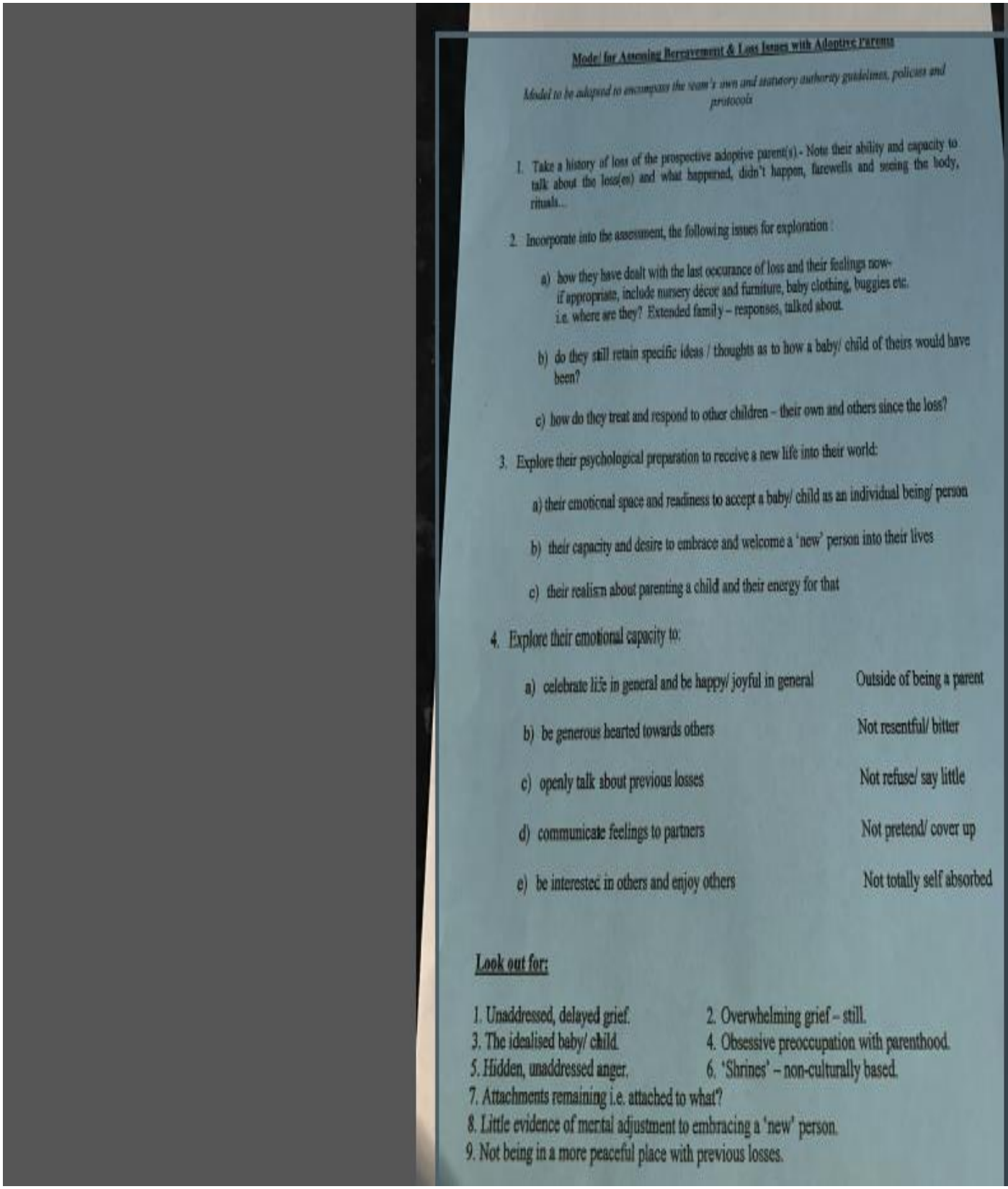
The full 35 minute documentary entitled 'Empty Arms' is part of the materials used in the training of bereavement counsellors and therapists and is delivered on Day 2 of the 6-day training at WBS.

The documentary was filmed at South West London, St George's Hospital NHS Trust.

2010 A. Smith Training Materials

APPENDIX 35

Model for Assessing Bereavement & Loss Issues with Adoptive Parents



Model for Assessing Bereavement & Loss Issues with Adoptive Parents

Model to be adapted to encompass the team's own and statutory authority guidelines, policies and protocols

1. Take a history of loss of the prospective adoptive parent(s) - Note their ability and capacity to talk about the loss(es) and what happened, didn't happen, farewells and seeing the body, rituals...

2. Incorporate into the assessment, the following issues for exploration :

   a) how they have dealt with the last occurance of loss and their feelings now- if appropriate, include nursery décor and furniture, baby clothing, buggies etc. i.e. where are they? Extended family – responses, talked about.

   b) do they still retain specific ideas / thoughts as to how a baby/ child of theirs would have been?

   c) how do they treat and respond to other children – their own and others since the loss?

3. Explore their psychological preparation to receive a new life into their world:

   a) their emotional space and readiness to accept a baby/ child as an individual being/ person

   b) their capacity and desire to embrace and welcome a 'new' person into their lives

   c) their realism about parenting a child and their energy for that

4. Explore their emotional capacity to:

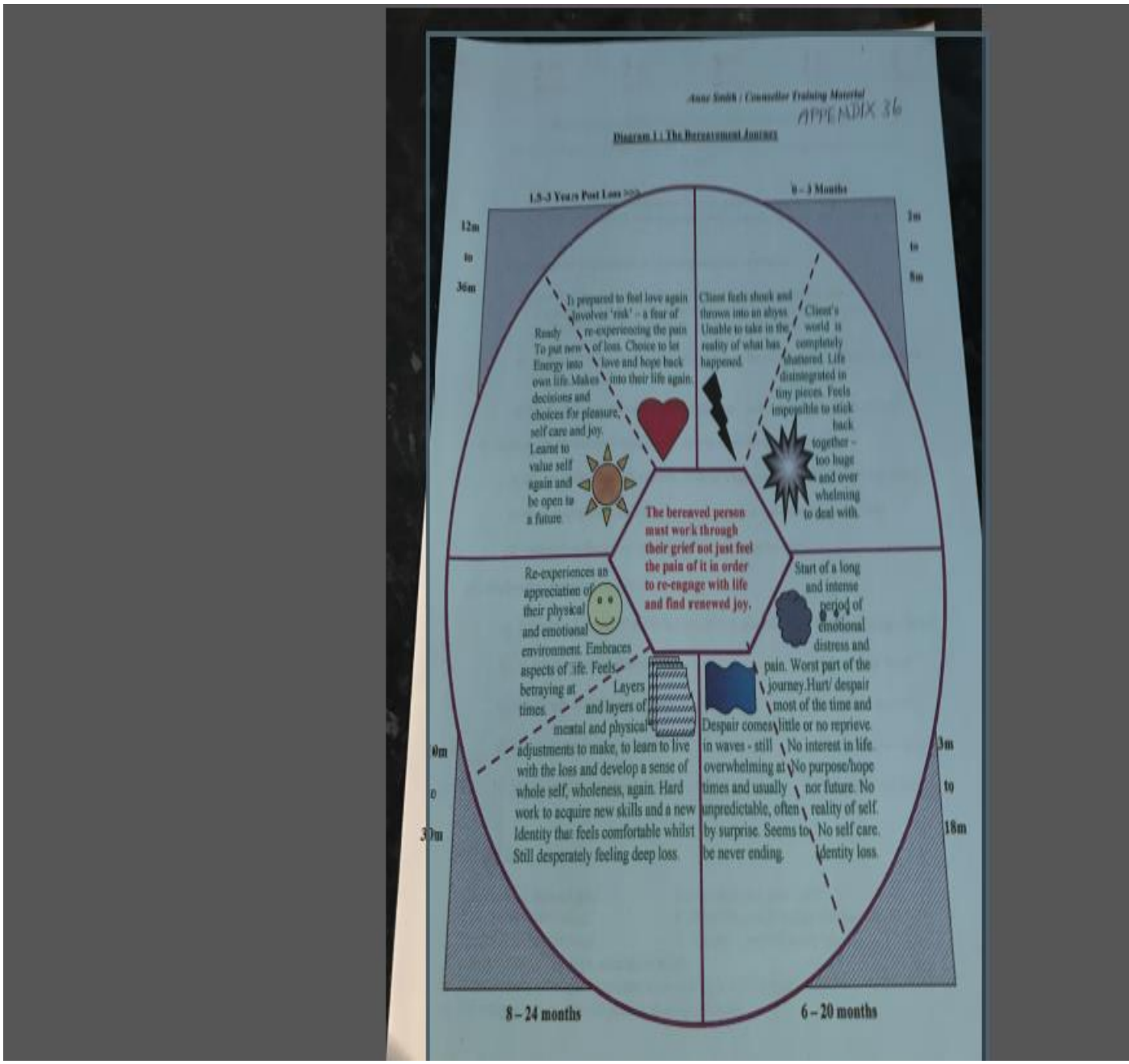
a) celebrate life in general and be happy/ joyful in general	Outside of being a parent
b) be generous hearted towards others	Not resentful/ bitter
c) openly talk about previous losses	Not refuse/ say little
d) communicate feelings to partners	Not pretend/ cover up
e) be interested in others and enjoy others	Not totally self absorbed

Look out for:

1. Unaddressed, delayed grief.
2. Overwhelming grief – still.
3. The idealised baby/ child.
4. Obsessive preoccupation with parenthood.
5. Hidden, unaddressed anger.
6. 'Shrines' – non-culturally based.
7. Attachments remaining i.e. attached to what?
8. Little evidence of mental adjustment to embracing a 'new' person.
9. Not being in a more peaceful place with previous losses.

APPENDIX 36

The Bereavement Journey with Time Lines: Early formulation, later discarded



APPENDIX 37

Cruse Bereavement Care Wirral - Training Day

Continuing Bonds

End of course evaluation sheet Report

Attendees – 16 Eval sheets returned – 11	Date **16th November 2013**
Trainer **Anne Smith**	Venue **Hoylake Parade**

2. **Has the course fulfilled your expectations?** Please comment

Yes, I would say it has exceeded my expectations

Didn't know what to expect.

Yes, Ann conveyed a wealth of information in an accessible way.

Yes, totally – I had some knowledge of CB but really wanted to find out how the theory worked in practice. The range of activities used ensured this happened.

YES. I thought the subject matter made a great deal of sense. The day was easy to follow and there wasn't enough time really.

Yes it was extremely interesting and explained fully the concept of Continuing Bonds

Very much so

Being a person-centred counsellor, I found the course gave me a sense of freedom to be able to help a client in a directive way. Learning about the many ways an individual can continue bonds with their loved ones was most helpful – knowing it's ok and beneficial.

Very much, an excellent day

Yes. I had some knowledge of the subject – the day expanded my knowledge & the importance of the subject in bereavement work

I had great expectations from Anne having attended one of her training days before - she didn't disappoint and I was engaged for the whole day.

4. Key objectives of the day were

5. 1) To convey the significance and role of continuing bonds in bereavement and grief work; and
2) To enable you to confidently apply continuing bonds in your therapeutic work with clients**.**

How do you feel the training met these objectives? Please circle

Very well **(11)** fairly well well enough not at all

Please comment:

It has given me a better understanding of what continuing bonds means, what presents as normal and healthy and what is not and could be detrimental to recovering from a loss.

I was very surprised how it could be used in our work.

It clarified what I already knew through experience and from instinct.

It is rare that I would circle "very well" as I do sometimes lack confidence in applying the training. But, on this occasion I felt very well supported in achieving the objectives and also feel that some of my practice has been affirmed through the knowledge gained and skills learned and extended.

Anne was an excellent tutor and covered the topic and many others around it extremely well

Very clearly explained & delivered with Anne's usual clarity and diverse resources

Learning about the individual & idiosyncratic meanings to the bereaved, gave me more understanding of a person's need to continue a bond with the deceased loved one. It has enabled me to be aware of the needs of the individual in their bereavement.

Continuing bonds' were explained in detail and lots of examples discussed and looked at. I feel confident this will help me in my work.

Very well - will be a lot more confident encouraging continuing bonds clients show interest in and reassuring them they are normal.

4. Please list what you found most valuable and interesting about the course

The group work, sharing experiences. Also Anne our trainer who is interesting and very knowledgeable.

It was all interesting.

I particularly enjoyed the way Ann used contemporary films to illustrate her point. It was good to hear the outcome of a case history we studied, too.

Listening to Anne's experience. All her examples were related to our work.

The theory (I like knowing what the latest research is)

The group activities – really learned a lot from working with other volunteers, very interesting to listen to how they do things etc.

Real life case studies – also it was fascinating to see how much can be learned about clients from transcripts.

Diversity discussion

It makes so much sense to work with continuing bonds so the whole day was very good and fitted well with the work we do a Cruse.

In the group work it was very helpful to hear others' experiences with their clients and how they dealt with them.

The fact that continuing bonds can be seen as valid. That people can deal with their grief & the issue of continuing bonds in many different ways

Listening to you Anne, because you make it all so interesting. The hand-outs – Remembering not to forget. The case study about a family affected by a murder and their individual reactions was most insightful. Interviews by Piers Morgan and how loss impacts on a person. Looking at the photograph of mourners after the death of Princess Diana – collective grieving & individual grief.

The explanation of all the issues and the wealth of knowledge of the presenter.

Various methods used –all helpful; i.e. DVD's, case-studies & transcripts all valuable. Small and large group discussions also very useful.

Learning that continuing bonds are idiosyncratic - as individual as each bereaved person; and knowing there is a fine line between remembering a loved one and being stuck in grieving process and being able to recognise the difference.

5. Please list what you found of least value and interest in the course

Nothing

Too many photographs.

Nothing

All valuable and all interesting.

Nothing

All the topics covered were valuable

Nothing at all

All relevant

Nothing

Nothing

Nothing

5. Suggestions for changes / omissions / additions to the course

None

Discussing one photograph at a time

Although Ann is an extremely good communicator, I would have appreciated more inter-active exercises in pairs or small groups. Maybe less information and more time to reflect on and engage with it. A couple of times I did feel my eyelids growing heavy, even though I was interested in all Ann had to say!

None – all good.

None

Nothing

none

None

It might have been better to have smaller groups for the discussions, the tables were needed as Anne gave out a lot of material for us to look at.

As all the learning was examining case studies followed by discussion, a different learning experience may have been helpful (I'm nit-picking here!)

The loudspeaker on the laptop was not loud enough for that room.

Only finishing earlier - but understand Anne comes from North wales, so appreciate this isn't always possible.

6. Overall course satisfaction – please circle one number

Extreme dissatisfaction				extreme satisfaction
1	2	3 **(1)**	4 **(3)**	5 **(7)**

7. Any comments about the venue

Venue was fine, enough space, could get a drink, comfortable.

Very good

It was very clean and well-maintained – a credit to the caretaker and I told him so!
Great venue, room a bit cold but the caretaker did put the heating back on. Perhaps we could have had a couple more tables in the room so the groups could spread out.
Good as usual

Good venue. Easily accessible by road or train. Pleasant room

A good venue with good parking & facilities

Nice venue although some distance to travel

A good venue and another lovely bright day. Staff very helpful.
Lovely bright room with excellent facilities. Nice to be able to move rooms to have lunch.

8. Any additional comments about the day overall

Really good, time well spent, more Anne Smith please!

Really interesting

Thank you for arranging it, I was glad to be there.

Perhaps consider a 3.30 finish (could have 30 minutes for lunch and perhaps 15 mins off the afternoon session).

Excellent

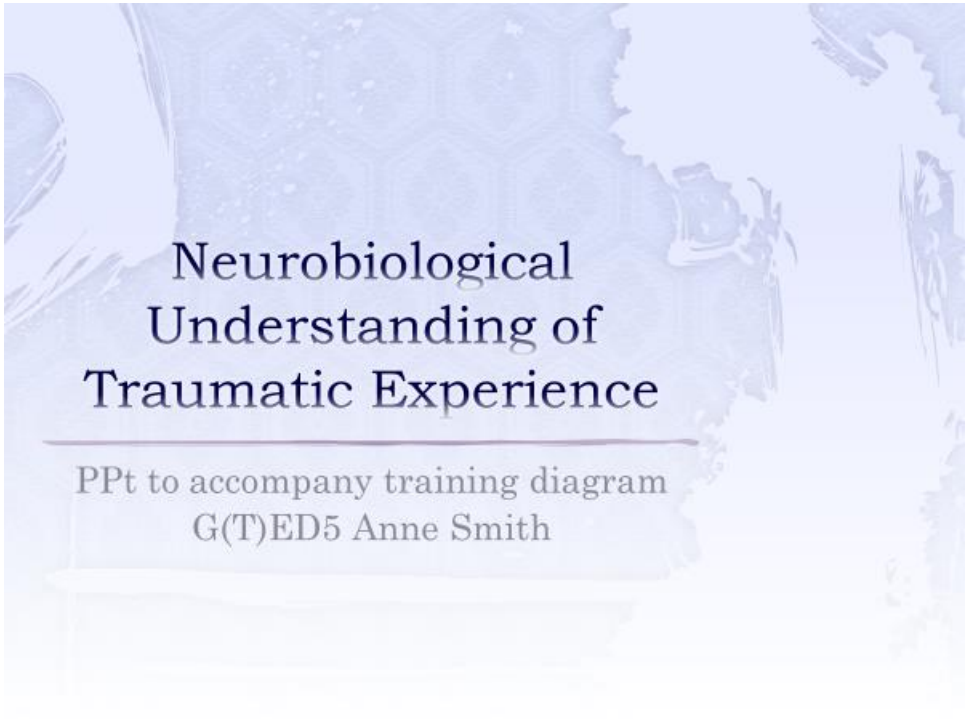
I found it was a good opportunity to meet some more of the Cruse volunteers

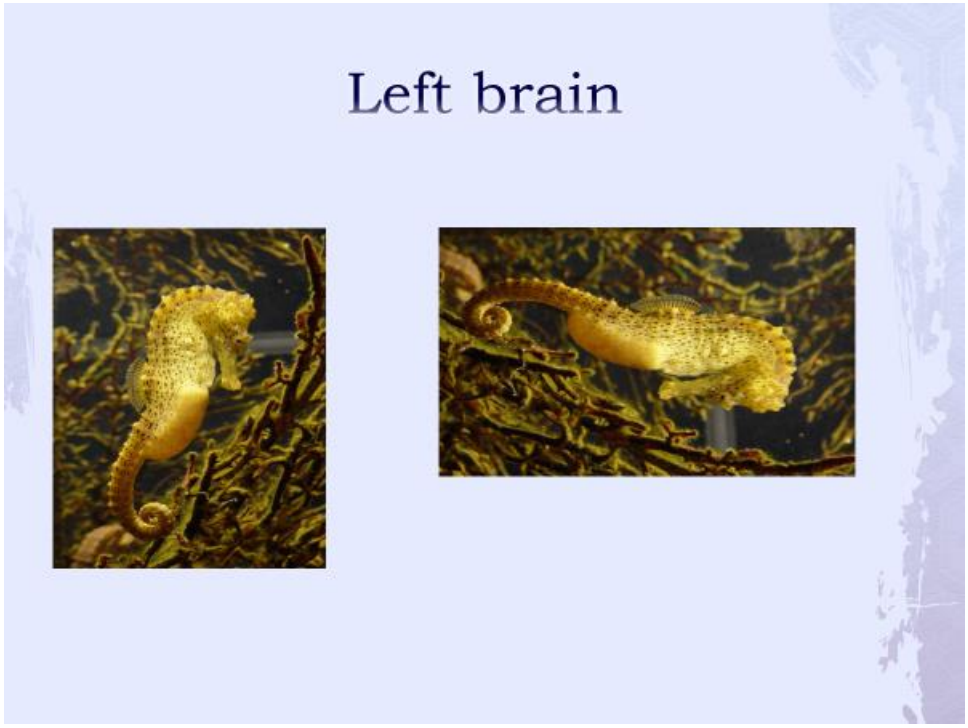
Anne is a superb trainer & brings her wealth of experience to the issues of grief in its many guises.
Went home feeling more confident about my counselling practice. Felt I had acquired more tools to enable my clients to journey through their grief. Thanks

A really good buzz among the participants except some felt a half hour would have been ok for lunch with a 3 30 finish. However the presenter needs to be thought about and needs a certain time.

Anne is just brilliant, we must not lose contact with her, and very generous with her material.

The Neurobiological Understanding of Traumatic Experience





Memory & Noesis (Knowledge)

- Semantic memory: concerned with facts – symbolisation of external or internal facts; communicated in word form or imagery.
- Siegel (1999): declaration of semantic knowledge can be assessed as true or false.
- Semantic knowledge lets people know about facts in the world; a process called noesis.

Noesis and Autonoesis

- Episodic memory: memory of self across time; episodic memory emerges from **autobiographical** foundations and is-
- seen as requiring a 'capacity of **autonoesis**' (Siegel,1999: 35) which -
- Gives rise to **self knowing**
- The frontal cortical region of the brain generates autonoetic consciousness.

Autonoesis

- **Autonoetic consciousness** allows a person to have 'recollection of self at a particular time in the past, in the lived present and projections of self into the imagined future' (Siegel,1999: 35).
- Siegel captures the very essence of autonoesis by coining the phrase **'mental time travel'** (Siegel,1999: 35).
  Mentalisation

'Attractor state'

- Phenomenon: the individual is mentally drawn, or 'attracted' to thinking in a particular way as a result of emerging states that have evolved over time.
- These can be **recursive in nature**, reinforcing any negative impact upon the individual from earlier emerging states to continue to **influence the individual's response in the present.**
- 'This recursive quality reinforces patterns of representational response learned from earlier encounters with the world' (Siegel,1999: 222).

Resonance: right and left brain

- Integration of **explicit** and **implicit** memory:
- Implicit memory – unilateral position
- Explicit memory engaged – bilateral process between –
- right (ventral) and left (dorsal) hemispheres of the brain = **bilateral resonnance >**

Autobiographical narrative

- The bilateral process (inter-hemispheric integration) develops a **coherent autobiographical narrative** or account.
- 'Rogers may have described the best interpersonal environment for brain growth during the development and change in psychotherapy' (Cozolino, 2002: 52).

Therapeutic attunement

- Affective expression is located within the right hemisphere.
- Verbal communication belongs to the left hemisphere.
- Right brain to right brain; left brain to left brain resonnance between client and therapist > **left-right-bilateral resonnance**
- Two minds communicate fully promoting **therapeutic attunement**

Cognitive functioning – left brain

- Aims to make sense of events that have taken place;
- to identify and plot the sequence of things that have happened
- to contextualise the event in its entirety to fully comprehend
- to implement appropriate action (where required) following what has been learnt.

Emotional experience – right brain

- The Amygdala holds the actual emotional experience;

- Stimuli from the five senses
- Affective states – 'mentalizing' (Siegel)
- Autonoetic process
- Mentalisation – representations of events

- **NO spacio-temporal quality** or dimension present in the amygdala:
- No sequence of events
- No coherent narrative
- No clear memory
- No logical thinking
- No time frame
- No planning

Amygdaloidal-Hippocampal functioning

- 'The amygdala has a central role in the emotional and somatic organization of experience, whereas the hippocampus is vital for conscious, logical, and co-operative social functioning. Their proper functioning and mutual regulation are central to normal functioning' (Cozolino, 2002: 96).
- Taxon, fast system (amygdala) and Locale, slow system **are 2 separate systems**; taxon located in right brain; locale in hippocampus which is 'activated' upon bilateral processing.

Continued…

- 'the implicit and the explicit must be bridged in order to create a cohesive narration [ ] to place them (memories) in their proper slot in the client's past' (Rothschild, 2000: 161).
- The context free amygdala, without temporal-spatial knowledge to inform decisions or actions, requires hippocampal functioning for integration (Smith, 2010)

Agonic state of agonicstasis.

- Amygdaloidal-hippocampal interaction (bilateral processing) is essential for homeostasis and emotional stability.
- When trauma symptoms are triggered, the individual's biological and physiological condition is in the agonic state of agonicstasis.

Hedonic to Agonic State

- Cantor (2005) captures this with his term 'agonic switch' and asserts that:
- 'The costs of the agonic switch are greater in hedonically orientated species such as ourselves, especially in civilised times' (Cantor, 2005: 182).
- Hedonic to agonic mode is present following traumatic death and bereavement experiences, with sensory stimulated mental representations stored in the amygdala, being triggered and re-activated giving rise to a high level of traumatic stress arousal (Smith, 2010).

Therapist's Challenge!

2015 A. Smith Training Power Point

APPENDIX 39

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